

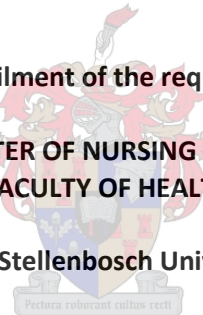
# **EXPERIENCES OF CHRONIC PATIENTS ABOUT LONG WAITING TIME AT A COMMUNITY HEALTH CARE CENTRE IN THE WESTERN CAPE**

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Thesis presented in fulfilment of the requirements for the degree of

**MASTER OF NURSING SCIENCES  
IN THE FACULTY OF HEALTH SCIENCES**

**at Stellenbosch University**



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Co-Supervisor: Dr Ethelwynn Stellenberg

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## DECLARATION

By submitting this research assignment electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the author and owner thereof and that I have not previously, in part or in its entirety, submitted it for obtaining any qualification.

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## ABSTRACT

The objectives of this study were to explore patients' experiences about long waiting time at the Vanguard Community Health Care Centre in the Western Cape and to explore possible solutions for this problem from the patients' perspective. A qualitative research approach was applied. A sample size of (n=12) was drawn from a total population of 2829 (N=2829) using a non-random convenient sampling technique. A semi-structured interview guide was designed based on the objectives of the study and validated by experts in the field before data collection took place. Approval for the study was obtained from the Ethics Committee at the faculty of Health Sciences, Stellenbosch University and from the facility manager of health centre where the study was to be undertaken.

The presentation of the results was categorised into themes and sub-themes that emerged from the data analysis. According to the findings in chapter 4 the themes that emerged were:

- Causes of long waiting time
- Areas of concern where waiting occurs most
- Emotions experienced when waiting long for service
- Possible solutions to waiting long for service

The findings support the conceptual framework developed for the purpose of this study which includes the Patient's Bill of Rights, the Principles of Batho Pele, Quality Care, Patients' Representation and Patient satisfaction. The results of the study suggests that the conceptual framework needs to be implemented as a guideline to address the problems of long waiting time with the input from the participants' opinions about possible solutions to be incorporated to the problem of long waiting time at the community health centre.

**Key words:** Patients, waiting time, community health centre.

## OPSOMMING

Die doelwitte van die studie was om pasiente se gevoelens oor lang wagtye by Vanguard Gemeenskapsgesondheidsentrum in die Wes-Kaap te ondersoek en om moontlike oplossings vir hierdie probleem vanaf die pasient se perspektief te bepaal. 'n Kwalitatiewe navorsingsbenadering is gebruik. 'n Steekproefgrootte van ( $n=12$ ) is verkry vanaf 'n totale bevolking van 2829 ( $N= 2829$ ) deur die gebruik van 'n nie-ewekansige gerieflike steekproefneming tegniek. 'n Semi-gestruktureerde onderhoudgids is ontwerp gebaseer op die doelwitte van die studie. Die onderhoudgids is geldig bevind deur spesialiste in die gebied voor data insameling plaasgevind het. Goedkeuring vir die studie is verkry van die Etiese Komitee by die Fakulteit Gesondheidswetenskappe, Stellenbosch Universiteit en van die bestuurder van die gesondheidsentrum waar die studie uitgevoer sou word.

Resultate is rangskik in temas en subtemas wat afgelei is van die data analise. Die volgende temas is bepaal vanuit Hoofstuk 4 se bevindinge:

Redes vir lang wagtye

Areas waar lang wagtye voorkom

Emosies ondervind wanneer lank gewag moet word vir diens

Moontlike oplossings vir lang wagtye

Die bevindinge ondersteun die konseptuele raamwerk ontwikkel vir die doel van die studie wat die Handves van Regte vir pasiente, die beginsels van Batho Pele, Kwaliteitsorg, Pasient verteenwoordiging en Pasienttevredenheid insluit. Die bevindinge van die studie dui aan dat die konseptuele raamwerk geïmplementeer moet word as riglyn om die probleme wat ervaar word met lang wagtye aan te spreek. Die deelnemers se menings oor moontlike oplossings moet deel moet wees van die aanspreek van die probleem van lang wagtye in die gemeenskapsgesondheidsentrum.

**Sleutelwoorde:** Pasiente, wagtye, gemeenskapsgesondheidsentrum

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Vuyiswa Tana

## DEDICATION

*To my mother for being there for me;  
my late father who must be proud of me where he is;  
my late brother; and  
my dearest daughter for her understanding and support*

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## LIST OF ABBEVIATIONS AND ACRONYMS USED

<b>CHC</b>	Community Health Centre
<b>COSMOS</b>	Community Service Medical Officers
<b>HPO</b>	Health Promotion Officer
<b>HUKM</b>	Hospital University Kebangsaan Malaysia
<b>NHS</b>	National Health System (of England)
<b>OPD</b>	Outpatient Department
<b>PMO</b>	Principal Medical Officer
<b>SA</b>	South Africa
<b>SAHRC</b>	South African Human Research Council
<b>SASO</b>	Specialised Auxiliary Services Organisation
<b>SMO</b>	Senior Medical Officer
<b>USA</b>	United States of America
<b>WHO</b>	World Health Organisation

## **CHAPTER 1**

### **SCIENTIFIC FOUNDATION OF THE STUDY**

#### **1.1 Introduction**

The topic of this research is “Experiences of patients about long waiting time at a community health centre in the Western Cape”. This chapter provides an overview of the study, providing the rationale for the study, the research question, the goal of the study, research methodology, definitions and chapter outlines. The rationale for the study will emphasize the need for the information obtained by this study. The research problem will be refined into a research question in order to clearly state the goal and objectives of the study. Thereafter, the methodology adapted for this study will be discussed and all the chapters and their content will be outlined.

#### **1.2 Rationale**

Internationally, the ratio of patients to staff is enormous and this factor contributes to long waiting times and thus lack of quality of care perceived by the patient (Ssemaluulu & Adome, 2006; Steyn & Levitt, 2005:244; Ajayi, 2002:121). Umar, Oche and Umar (2011:82) report from Africa (northern Nigeria) that in the public health sector patients experience dissatisfaction with health care service delivery because of long waiting. In South Africa, the South African Demographic and Health Survey (2003:1) reports on patient dissatisfaction due to the long time they have to wait in order to be seen. Breier (2008:11) confirms the long waiting time for services and blames this on South Africa's critical shortage of doctors. Turkson (2009:68) mentions that inadequate, overworked staff cannot produce good and satisfactory results. In the Western Cape, Vallabhjee (2011:44) finds that long waiting time still remains a major challenge at many primary clinics, and that bottlenecks at some service points indicates poor management.

Jaffrey & Miti (2010:61) agree that a shortage of staff has a negative impact on the delivery of services. This, in turn, is experienced as poor service rendering by the patients making use of the service, with the media acting as their spokesperson. Jooste & Maditla (2011:1) from the Cape Argus published an article about several of the City of

Cape Town's clinics which on inspection, showed alarming overcrowding but also a lack of equipment and crumbling infrastructure.

Primary Health Care delivery is the pillar on which health care services are built. According to WHO (1978: 428), Primary Health Care is essential health care, based on practical and scientifically sound and socially acceptable methods and technology, universally accessible to all in the community through their full participation, at an affordable cost and geared toward self-reliance and self-determination. It is the first level of entry for a patient, and focuses on prevention and promotion of health care problems. This is also the level where those needing it will be referred to secondary or tertiary health care providers (WHO, 1978: 428). At primary health care service level there is a general focus on the prevention of health care problems and the promotion of health and the early detection of poor health. Patients are referred from this level to secondary and tertiary services for further management of detected disease if they cannot be managed any further at the primary level (WHO, 1988:15).

All services, especially those funded by the tax payer's money, are open to scrutiny by the public that funds them. To be able to ensure the public that value is received for money invested, quality of care rendered needs to be proven by the health care facility. The South African government has put a few measures in place to ensure to the tax payer and the user of the public service that adequate, responsible and accountable services would be rendered. The constitution of the Republic of South Africa, Act No.108 (South Africa 1996: 13) says that citizens have the right of access to effective health care services. The patients' Bill of Rights formulated in 1999 by the South African government confirms the patients' right of access to health care and adds that the patient needs to be treated with respect and dignity. The Batho Pele Principles formulated and propagated since 1997 by the South African government attempts to encourage public servants to "put people first". All of these measures are concerned with treating the public that uses the services with courtesy, consideration and to redress the problems that the public has with service delivery (Khoza, 2009:15).

Patients' needs and interests must thus receive priority before any other needs. How does one know whether the patient's needs and interests have been addressed? Measurement of client satisfaction can be used to comment on the quality of care that was rendered (Patro, Kumar, Goswami, Nongkynrih & Panday, 2008), and it needs to be



measured frequently so that health care planners would take into consideration the actual needs of the population served (Ahmad & Din, 2010:95). This will ultimately improve health care outcomes and quality services (Fomba, Yang, Zhou, Liu & Xiao, 2012:1). Too often patients are disempowered and have the least say in what a quality health care service should look like. Patients are often emasculated, disenfranchised and ignored in the unionized fights for better salaries and packages by health care staff. Patients, rather than professionals should define and evaluate their care needed (Chaka, 2005:3).

Dennil, King and Swanepoel (2003:81-82) mention that it is the democratic right of citizens to be involved in issues that affect their lives. Thus the patient should be at the centre stage of the health care service and his experience of service should be measured as one of the outcomes (Kumari, Idris, Bhushan, Khanna, Agarwai & Singh, 2009:1 and Rossouw, 2010:1). Rossouw (2010:1) has outlined the Western Cape health care strategy for 2020 and it includes a focus on the patient's experience of service, to improve health outcomes through monitoring and evaluation and to enhance Primary Health Care services. Turkson (2009:68) mentions that the Department of Health cannot claim to be delivering quality health care service to the patients while patients remain dissatisfied with the health care service delivery. The problem of perceived poor quality of service is a longstanding one, as Prentice and Pizer (2007:6) already mentioned that poor quality of care and management negatively affected service delivery in 2007 - a mere 10 years after the Patient's Bill of Rights was accepted by the public services.

There seems to be an inability to deliver what the government propagates and what patients rightly expect. This study seeks to identify what is known and unknown about long waiting times by focusing on the citizens' or patients' view of quality of care received. As the most important role-player and receiver of this care their voice needs to be documented to make a positive impact on the care they receive in this democratic society. Previous research studies and surveys have been conducted with no improvement in health care service delivery. This study will attempt to elicit the patients' opinions and to advocate for that opinion to be considered in this quest for quality care.

### **1.3 Problem Statement**

The researcher observed that long waiting time for services is a challenge that affects health care service delivery. Long waiting time undermines the image of the public health care sector. Long waiting time for service is a longstanding problem with no progress made towards correcting the situation. The receiver of the health care, the patient, experiences long waiting on a daily, weekly or monthly basis. The patient's opinion is a valuable measurement regarding the quality of health care received and experienced. For these reasons, research was required to explore the phenomenon of long waiting time at a community health centre from the patient's point of view.

### **1.4 Research Question**

What are the experiences of patients with chronic diseases about long waiting time at a community health centre?

### **1.5 Goal of the Study**

The goal of the study was to explore the experiences of patients with chronic diseases of a community health centre about long waiting time.

### **1.6 Research Objectives**

The objectives of the study were:

- To explore patients' feelings about long waiting time, and
- To explore patients' solutions to the problem of long waiting time for services.

### **1.7 Research Methodology**

The research methodology for this study will be described and discussed in detail in Chapter 3, but a brief outline follows below:

#### ***1.7.1 Research design***

This study will follow a qualitative approach with a phenomenological design. This qualitative research will focus on understanding the phenomenon of long waiting time as experienced from the patients' point of view. The patients' opinion about the reasons, the effects and possible solutions for the problem will be sought.

### **1.7.2 Population and sampling**

The population in this study were chronic patients with diseases of lifestyle, like diabetes, hypertension and asthma. These patients visit the community health centre on a monthly basis and therefore of all the attending patients these patients experience the inconvenience of long waiting times the most. According to the records of the CHC, the total population patients with these chronic disease of lifestyle are (N=2918). **Inclusion criteria** were patients with chronic diseases of lifestyle, like diabetes, hypertension and asthma who had visited the community health centre for more than a year. Non-chronic patients, newly diagnosed patients with chronic diseases of lifestyle, children and pregnant mothers attending CHC were **excluded** from this study.

A sample size of (n=12) was decided upon, as this is a number where qualitative studies usually reach saturation of the information needed (De Vos, 2005: 270). The sample method was a non-probability convenient sample where patients who attended the CHC on that day were interviewed. The chronic patients waiting to be seen were given an explanation about the study and asked to volunteer to participate in this study.

### **1.7.3 Instrumentation**

A semi structured interview guide was designed based on the objectives of the study, the review of the literature and the researcher's own experiences. The interview guide was further validated during a meeting of nurse researchers at the Stellenbosch University before the proposal was sent for ethical review.

### **1.7.4 Pilot study**

A pilot study consisting of five interviews was conducted with a participants that met the criteria of the study before the interviews of the selected sample were initiated. The pilot study helped to identify issues to deal with regarding the use of the recorder and computer software for data analysis.

### **1.7.5 Validity of the research**

Specialists from Stellenbosch University's Department of Nursing assisted with the suitability and relevance of questions for the semi-structured interview guide. Trustworthiness of the data was authenticated with the criteria of credibility, transferability and dependability as will be described in Chapter 3.

### **1.7.6 Data collection**

A semi-structured interview was done with the aid of a tape recorder to ensure that all data was captured. Permission was obtained from the participants to record the interview.

### **1.7.7 Data analysis**

Data analysis was done after the interviews were transcribed. Themes and sub-themes were identified and these are discussed in Chapter 4.

### **1.7.8 Ethical consideration**

Permission to do the study was obtained from Stellenbosch University's Ethical Committee, from the management at the CHC where the interviews took place, as well as from the participants. At the beginning of each interview each participant was given a 'Participant Information Leaflet' concerning the study and written consent was obtained from all participants to be interviewed and audio-taped.

Participants were assured of anonymity and that the researcher had an obligation to maintain confidentiality by not divulging the names of the people who gave their opinions of the service (Brink, Van der Walt & Van Rensburg, 2008: 34- 35). The interviews were conducted by the researcher in a private consulting room at the CHC, where the rest of the staff would not know who was and was not interviewed. Data was locked and stored in a safe place at the residence of the researcher who was the only person with access.

## **1.8 Limitation of the study**

One possible limitation of the study is that it focused solely on chronic patients who visited the community healthcare centre and who have experienced long waiting times at the CHC. Non-chronic patients such as pregnant mothers, children and trauma patients were excluded from the study.

## **1.9 Conceptual framework**

The conceptual framework for this study is mainly based on the Queuing Theory. The Queuing Theory explains how a queue is formed and what influences the queue formation. Another aspect of the conceptual framework is a concept that is formulated to bring about patient satisfaction. This concept is applied by healthcare providers during

the process of care at a healthcare facility, and it includes the patients' Bill of Rights, Batho Pele Principles, Quality of Care, Patient Representation and Patient Satisfaction.

## 1.10 Operational definitions

**Waiting time:** Waiting time is the period from registration until medication is received (Abdullah, 2005: 40).

**Patient:** A patient is one who receives medical attention care or treatment (*The American Heritage Stedman's Medical Dictionary*, 2007).

**Community Health Centre:** A Community Health Centre (CHC) is defined as a facility that in addition to a range of primary health care services, normally provides 24 hours of maternity, accidental and emergency services, with up to 30 beds where patients can be observed for a maximum of 48 hours. There will be a procedure room but not an operating theatre. Patients are not given a general anaesthetic and are not admitted as inpatients (Cullinan, 2006: 1).

**Chronic diseases of lifestyle:** these are any group of diseases that share similar risk factors because of exposure over many decades to unhealthy diets, smoking, lack of exercise and possibly stress. Examples are diabetes, hypertension and chronic obstructive airways diseases. These result in various long term disease processes, culminating in high mortality rates attributable to strokes, heart attack, chronic bronchitis and renal failure (WHO, 2005).

**Service quality:** Service quality is the delivery of excellent or superior service relative to customer expectation (Alrubaiee, 2011: 105).

**Patient satisfaction:** Patient satisfaction is defined as the consumer's views of services received and the results of the treatment received (Ibrahim, 2008: 1).

**Primary Health Care:** Primary Health Care is essential health care based on practical and scientifically sound, socially acceptable methods and technology, universally accessible to all in the community through their full participation, at an affordable cost and geared toward self-reliance and self-determination. It is the first level of entry for a patient, and focuses on prevention and promotion of health care problems. This is also

the level where those needing it will be referred to secondary or tertiary health care providers (WHO, 1978: 428).

### **1.11 Study outline**

Chapter 1 presents the background and motivation for the study and provides an overview of the literature, research question objectives, research method, definitions and research outline. In Chapter 2 the relevant literature is reviewed and discussed and concepts are developed in order to formulate a conceptual framework for this study. Chapter 3 provides an in-depth description of the research methodology, while Chapter 4 presents the results of the study with analysis, interpretation and discussion. The final chapter discusses the results of the study in light of the research objectives. Conclusions and recommendations are made based on the findings presented in the Chapter 4.

### **1.12 Conclusion**

This chapter has outlined the rationale of this study, stated the research question, outlined the research methodology and dealt with some ethical considerations. Chapter 2 will present the literature review on long waiting time and also highlight theories as well as the conceptual framework underpinning this study.

## **CHAPTER 2**

### **LITERATURE REVIEW**

#### **2.1 Introduction**

This chapter contains a review of literature about the experiences of patients of long waiting time. The review focuses firstly on the experiences of patients about long waiting time as reported in research studies and the media in the South African context (generally based on material not more than a decade old), then further afield in the broader African context, and lastly on the international front. The chapter then looks at the Queuing Theory in waiting for services before the findings of the literature are discussed and a conceptual framework linked to the reviewed literature is outlined.

#### **2.2 Prevalence of Long Waiting Time for Health Care Service**

Waiting time does not seem to be unique to the South African context. Developed and underdeveloped countries share this inability to resolve the problems which result in health care users experiencing services as lacking in quality. This is particularly a problem in the areas where the majority of people are dependent on the government for delivery of services. The following sub-sections will look at literature on long waiting time in South Africa (sub-section 2.2.1), the rest of the continent (sub-section 2.2.2) and internationally (sub-section 2.2.3), before drawing common themes from these different contexts (2.2.4).

##### ***2.2.1 Long Waiting Time for Health Care Services: The South African Situation***

The majority of South Africans use the public health sector for health care services (Peltzer, 2009:117). According to the Board of Healthcare funders of South Africa, only 16 percent of the South African population has medical aid schemes and are not dependant on public health services (BusinessLIVE 2011). Although there is a component of people without a medical aid scheme that do visit private health providers, most does not fall in an income category to do so and thus need to use the public health care services available .

Ntethe, Mokgathe-Nthabu and Ongatibeji (2010) describe primary health care as a basic health care service designed to be cost effective, and to bring health as close as possible to the people. Primary health care is the first point of entry into the health services at a clinic or CHC level for the sick person and it covers a comprehensive range of preventive, promotive, curative and rehabilitative services (Cullinan, 2006). According to Raynes, Blockman, Bainer and Trinder (2007: 284) the majority of patients that attend primary health care at CHCs are unemployed, pensioners and those depending on disability grants. Employed persons and students make up only 19% of those that attend the Community Health Centre (CHC). A sick person usually does not have any other choice than to first present themselves at this level of service in order to be referred to specialists later on at the secondary and tertiary levels. In contrast, patients with medical aids has direct access to a specialist of choice whenever necessary, and are thus seen sooner in their disease process than if they would have been referred via a general practitioner.

A CHC is defined as a facility that in addition to a range of other primary health care services also normally provides 24 hour coverage of maternity, accident and emergency services and has up to 30 beds where patients can be observed for a maximum of 48 hours. It includes a procedure room but not an operating theatre; patients are not given general anaesthesia, and are not admitted as inpatients (Cullinan, 2006).

Only a decade ago, clients reported overall satisfaction at health services (Searle, Miller, Ndhlovu, Fisher, Snyman & Sloan, 2003: 3) except for long waiting time. Five years later it was reported that most patients walk to health facilities and have to leave home early to arrive by 09H00 on opening of the clinic, when it is already congested. This causes overcrowding and long waiting times indicating that the problem has not been adequately addressed yet. Bottlenecks at pharmacies add to long waiting time at CHC (Du Plessis, 2008: 103) and the dispensing of medication is inefficient because of limited technology and few staff. Du Plessis (2008: 103) adds that chronic prescriptions that included multiple items take a while to get together and to dispense, and recruiting pharmacy staff has become a major challenge because of these unfavourable working conditions.

Steyn and Levitt (2005: 244) identified a number of reasons for the higher patient load at health care delivery areas: increasing numbers of patients, serious staff shortages, major budget cuts and the freezing of vacant posts in the public health sector. The increase in



patient numbers seen at primary health care institutions are the result of an ever increasing population and the fact that the secondary and tertiary institutions now force patients to first present at their local clinics. Freezing of posts is a well-known mechanism used by management to cope with restrictions on budgets (Rowe 2011:3) which further impacts on the problem of having to manage large numbers of patients. Patient loads are thus enormous and staff is angry and frustrated and seek work elsewhere. This prolongs the amount of time a patient has to wait for service.

The poverty-stricken have less access to health services and in rural areas this problem is exacerbated by lack of transport and long waiting time at health services. The findings in the South African Human Rights Commission's seventh *Economic and Social Rights Report 2006-2009* highlighted the insufficient access to health care for vulnerable groups such as women, pensioners and older persons (Seokama & Mukendi, 2009: n p).

The *Cape Argus* newspaper (Jooste & Maditla, 2011:1) published several articles about this problem in 2011. An article and photos of patients queuing outside Matthew Goniwe Clinic in Khayelitsha showed how people queued from as early as 4 AM to ensure that they will get entry into the clinic. An official from the mayoral committee for health in Cape Town mentioned in this report that the Matthew Goniwe clinic staff and other clinics cannot handle the volume of people requiring treatment and that buildings are falling apart.

Potential loss of employment is another effect of long waiting reported in a South African study at antenatal clinics. Women arrive early for their ante-natal appointments, in the hope of being first in the queue, but having to wait make them miss the whole work day, jeopardising their work situation (Beksinska, Mullick & Kunene, 2003: 311).

South Africa is continuously short of health personnel, especially doctors and nurses. Training and recruitment have not kept abreast of population growth and an increasing burden of disease imposed on the health system by the large and growing HIV/AIDS epidemic in country (George, Quinlan & Reardon, 2009:11. Closure of many nursing training institutions in the early 1990's and emigration has left the country devastated regarding health manpower.

The Department of Labour reports that shortages of doctors in South Africa is critical and is even worse in the rural areas (Breier, 2008: 11). Rowe (2011: 3) mentioned that

vacancies in the public sectors remain high because of difficulties in recruitment, also due to inadequate health care salaries offered. . The inability to adequately recruit staff has a negative impact on the capacity to deliver basic health services.

Hudson (2012: 4) reported the reasons why medical officers left the public sector:

- Poor working conditions including staff shortages, unhygienic facilities and work ethics, lack of medicine at clinics and hospitals;
- Inadequate remuneration packages;
- Lack of funded public sector posts in general;
- Unwillingness to do the one year community service
- To study abroad
- Inadequate safety and security at hospitals and clinics.

The ratios of population to health personnel is debilitating to both parties: patients do not get the care they need soon enough, and health staff are burnt out.

On recognising the results of these problems of service delivery, the legislative power (The Department of Health) drew up Core Standards to meet the challenges of long queues and waiting times especially in pharmacy and outpatient departments (Core Standards, 2006: 14-24). These Core Standards include:

- Leadership must be accountable for the delivery of quality care that meets patient needs within the available resources;
- Facility leaders (clinical and managerial) must collaborate in planning and implementing quality management and improvement programmes and staff must actively participate in these programmes;
- Patient experience of care must include initiatives to assess and improve patients' level of satisfaction and experience of care after using the health care service. Gaps between the expected service and the experience of the actual service from the patient's perspective need to be identified and addressed;
- The Patients' Rights Charter needs to be recognised.

### ***2.2.2 Long Waiting Time for Health Care Services: Other African Countries***

Further afield on the African continent, Afolabi and Erhun (2003: 214) found in Nigeria that the hospital system functions in a manner that all patients from all the departments in the hospital collect their medication at the pharmacy, resulting in queue formation and slower service delivery. Heavy loads of patients whereby doctors had to attend to 40-60 patients per day were the status quo (Afolabi & Erhun, 2003 and Ajayi, 2002). This caused excessive waiting time and delays that led to patient dissatisfaction and poor patient compliance. From Kampala in Uganda it was reported that 61% of patients waited at least over an hour for service (Ssemaluulu & Adome, 2006) due to high patient load.

The Democratic Republic of Congo has waiting time listed as a major barrier to accessing health care, as well as factors like transportation, inadequate funds, inability to identify a provider and rude healthcare professionals (Lutala, Kwayla, Basagila, Watongoke & Mupend, 2010).

Ibrahim (2008: 1) reports long waiting times in Ghana, especially at the dispensary or when going for an injection, and defines patient satisfaction as “the consumer’s views of services received and the results of the treatment received”. These negative experiences of waiting influences patients’ experience of service quality radically.

Studies from Mozambique identify long waiting time for services as a reason why people do not have proper access to health care. Patients simply default on their treatment as a result of having to wait so long for services (Decroo, Telfer, Biot, Maikere, Dezenbro, Cumba, Da Does, Chu & Ford 2011).

### ***2.2.3 Long Waiting Time for Health Care Services: The International Situation***

Long waiting time seems to be a problem globally. From Malaysia, Abdullah (2005: 40) defines waiting time as the total time from registration at the health service centre until medication has been obtained after consultation with the doctor. This author mentions that patients wait longest to see a doctor and to receive medicine. Operational problems eg the time it takes to register patients, insufficient staff numbers to register patients, and an insufficient amount of doctors to see patients contributes to long waiting time. Liabsuetrakul (2012: 22) reports from Thailand also in Asia, that shortage of doctors causes long waiting time, as does poor staff attitude.

From Canada, Hendershot, Murphy, Doyle, Van-Cleef, Lowry and Honeyford (2005: 31) reported that patients have to wait long for registration, that there is inadequate nursing staff tending to their needs and that there is a general lack of working and waiting space because of patient volumes. Patients were reported to experience increased stress levels, frustration and anxiety because of these factors, with waiting for a long time being **the worst** aspect of a clinic visit.

Matta and Patterson (2007: 174-192) identified unbalanced resource usage, inadequate patient flow patterns and poor scheduling practices, over-booking and poor staffing as factors that cause a series of long delays in American healthcare centres. Fox, Yurkiewicz, MacManus and Philleber (2010: 4) mention that long waiting time and long queues correlates with too short a time spent with the doctor. After having to wait for so long, patients forget to bring up their concerns because they felt hurried during the consultation. The doctor tends not to spend enough time on an examination and a thorough explanation about their condition due to consideration of the long line of patients still waiting. These factors cause a poor quality of service as it puts patients at risk of experiencing negative health outcomes (Prentice & Pizer, 2007: 67).

To conclude the issue of long waiting time, Hall (2006: 36-41) compares the series of long delays for the patient with that of the flow of a river: when the system works well, minimal delay occurs at each stage. When delays occur, patients accumulate like a reservoir and cause flooding to the system. The effects of this flooding especially influence the pharmacy area negatively as the last service point. The results are high levels of dissatisfaction with length of waiting time and extreme anger towards the pharmacist as the last period in the line of service rendering (Chandwari et al 2009:4, Liabsuetrakul. 2012:22). The National Health System's Institute of Innovation and Improvement in the United Kingdom (2008:1) has also had to address their problems with flow in provision of care and has presented relevant solutions to the problem, as discussed under paragraph 2.4.

#### ***2.2.4 Common Factors (causes, areas of concern and effects) Amongst Countries About Long Waiting Time at Health Care Facilities***

Dissatisfaction by patients about long waiting time is a reoccurring topic in the literature consulted. Causes of long waiting in South Africa, the rest of the African continent and the rest of the globe emerged as being:

- Issues with access to health care centre and lack of transport;
- Inadequate or unbalanced operational budgets to provide services and medicine;
- Inadequate buildings;
- Inefficient management and inability to regulate workflow to the needs of the service;
- Inadequate staffing and/or poor staffing schedules;
- Heavy patient loads;
- Patient inability to recognise the health care provider; and
- Anger and frustration amongst staff members experienced by patients as rudeness and lack of care.

Areas where the most bottlenecks and longest waiting for services happen are:

- At the place of patient registration;
- Consulting points where staff diagnose and prescribe treatment; and
- At pharmacies where dispensing of medication takes place.

The effects of long waiting time on those waiting include:

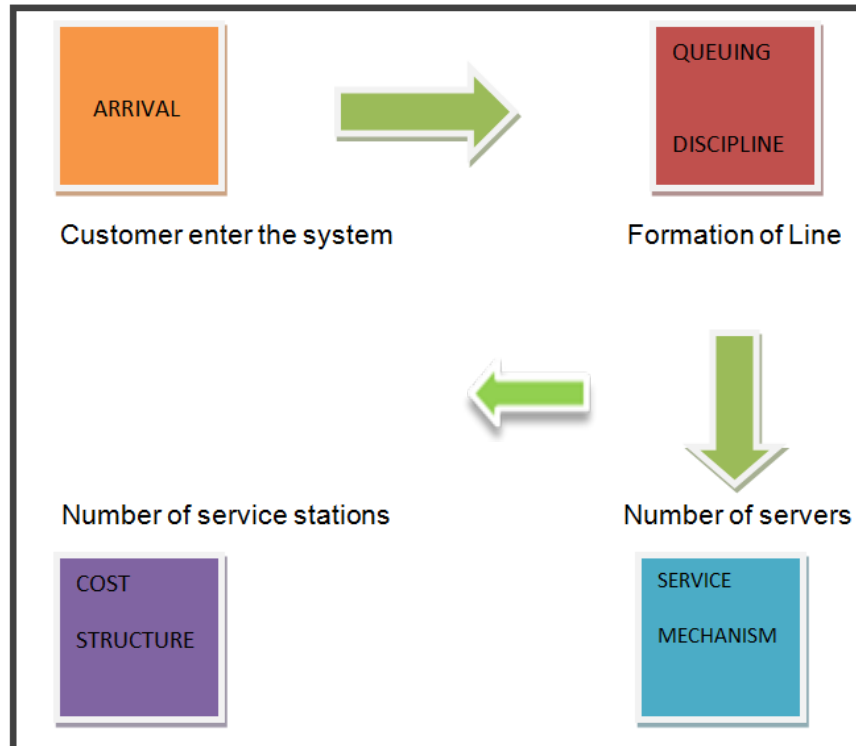
- Poor adherence to medication/health regime;
- Negative experiences of the service by the users of the service;
- Frustration and anxiety;
- Increased stress levels; and
- Inadequate health education received about medical problems.

In South Africa, the majority of population make use of public health care services. The poor, underprivileged and the vulnerable members of society are the ones mostly affected by the above problems as they do not have the options the 16% of medical aid covered patients have to choose between several private health services that compete with each other in the quality of care they offer.

## **2.3 Patient Flow and Queuing Theory**

Nosek and Wilson (2001: 275) mention a relationship between how people queue (Queuing Theory) and their perceived satisfaction with service. The system of queuing

can cause the customers to experience excessive, unexplained long waiting time, resulting in poor overall satisfaction with the service. Queuing Theory explains how a queue is formed and why customers wait long (Nosek et al., 2001: 276) as explained in Figure 1 below.



**Figure 1. Queuing Theory**

Queuing Theory is characterized by the following four elements:

- arrival;
- the discipline which dictates how people are going to queue and wait;
- the service mechanism available to handle the queuing persons;
- the budget available (cost structure) to deal with the whole operation.

The customers **arrives at the point of service** at a certain rate. When they arrive at a fast, unmanageable rate for the registration system to cope with, a queue is formed. Arrival may be single, in batches, randomly or at a consistent speed. At a CHC all of these ways occur as part of entering the health care system during operating hours. If the customer finds the line too long, he/she can decide to stay or balk. Balking is leaving instead of waiting if the line is too long (Nosek et al., 2001: 276).

The **discipline of the queue** determines how the queue is formed. It can be on a First-in-First-Out basis, where the patients arriving are seen in absolute order of arrival. Another discipline is a Priority Lane where certain customers receive priority care, like an express lane for customers that are the most sick, and need to be helped first (Nosek et al., 2001: 276). Formation of express lanes is of advantage to those patients who are attending the health care centre for example *only* for wound dressings, family planning, immunisations or administration of injections.

The service mechanism describes how a health care user is helped and how the **number of servers** available is used to provide quality service. The number of servers at a CHC can refer to registration (help desk officers as well as computer point's servers serving the computer points), health care providers (staff members, for example, doctors and primary health care nurses), and service points (for example, reception, observation room, injection room, dressing room, consulting room and pharmacy). The amount of servers available determines how long patients will wait. If only one server is available, unfortunately only one patient at a time can be attended to. The rest of the patients have to wait their turn. This causes a situation of hopelessness and frustration, and at this point other waiting patients decide to balk. If there is more than one server, customers can be helped sooner. The First-in-First-Out scenario is favourable and reasonable, but does not apply to all situations. Some patients have to go through a number of service stations where they take longer to be served and this sometimes results in instances of Last-in-First-Out, which is a very unfortunate situation.

The budget available to the institution determines **the cost structure**, which can allow for affordable and sufficient stations and speedy servers. The budget might be severely restricted, health costs could be rising and becoming unaffordable (Nosek et al., 2001: 276). The staff component of a health care service is generally the most expensive factor in a health care budget. If the budget falls short, management will have to find ways and means of saving whilst continuing to render the service. Often, the freezing of a post is seen as a way of saving, but this is often to the detriment of the remaining staff that have to cover the frozen post's number of patients too, as they usually are not allowed to turn patients away.

## **2.4 Patient Flow and Answers to Problems**

The National Health System's Institute for Innovation and Improvement in the United Kingdom (2008: 1) describes flow as the necessary uninterrupted progressive movement of products, information and people between departments. Reduction in delays of flow will ensure that the patients receive the proper care timeously, will improve patient outcomes and patients' experiences of quality of care. Hall (2006: 36-41) agrees that by improving patient flow, health services will ultimately improve. The following is mentioned by the NHS Institute for Innovation and Improvement (2008: 3) as requirements for a steady, uninterrupted flow:

- Provide services that supply the patient's demand;
- Improve issues at the end of the patient's journey (at the CHC this will be at the pharmacy);
- Then increase capacity and address the lack of flow through the rest of the pathway to the beginning of the journey (this could be at the consulting rooms and the registration area in the CHC);
- Reduce work and waiting that does not add clinical reasons to the patient; and
- Coordinate and pace work from beginning to the end.

Waiting causes obstructed flow and bottlenecks and thus further delays in service delivery. A bottleneck is an obstructed part of the system that results in delays and interrupts the natural flow and hinders movement along the care pathway, determining a slower pace at which the whole process works (NHS Institute 2008: 1). Service improvement will not succeed as the patient will just land in the queues faster and still be blocked further along by bottlenecks. A bottleneck is usually caused by a constraint. An example of an constraints can be the shortage of any of the staff at different points of the path. The bottleneck determines how fast the patient is helped (NHS Institute, 2008: 1).

## **2.5 Lack of Patient Flow, Patient Satisfaction and Quality of Care Experienced**

Lack of patient flow in a CHC causes bottlenecks and ultimately long waits in queues for most of the basic and necessary services to maintain the patient's health. Dr. Gavin Reegon (2010) from the University of the Western Cape lists waiting time as one of the



key focus areas that the National Department of Health should address to ensure quality care. Reegon (2010) mentions that long waiting time remains a source of much anger and bitterness among both the users and the health care providers in the public health care sectors. The users of service will not see their care as having any quality as long as they have to wait too long for service and as long as so little time is spent on them when finally attended to. This is confirmation of the main reason for dissatisfaction with health care amongst patients from Canada (Chamaco, Anderson, Safrit, Jones and Hoffman (2006: 409) where Salam, Alshakiera, Alhadi, Ahmed and Mohamed (2010: 1) classifies the experience of quality of care within primary health care to be affected by technical (equipment) but **mostly non-technical** (clients' waiting time and staff attitudes) **components**.

Chandwari et.al (2009: 1) mention that healthcare providers and programmes determine quality of care. If quality care exists, people will seek and continue to utilize these services. Haddad, Potvia, Roberge, Pineault and Ramodini (2000: 21-29) argue that the patient's experience of quality care needs to be integrated with application of professional standards. They state that this integration is necessary to meet the patients' expectations by involving them in decisions (Haddad et al., 2010: 21-29).

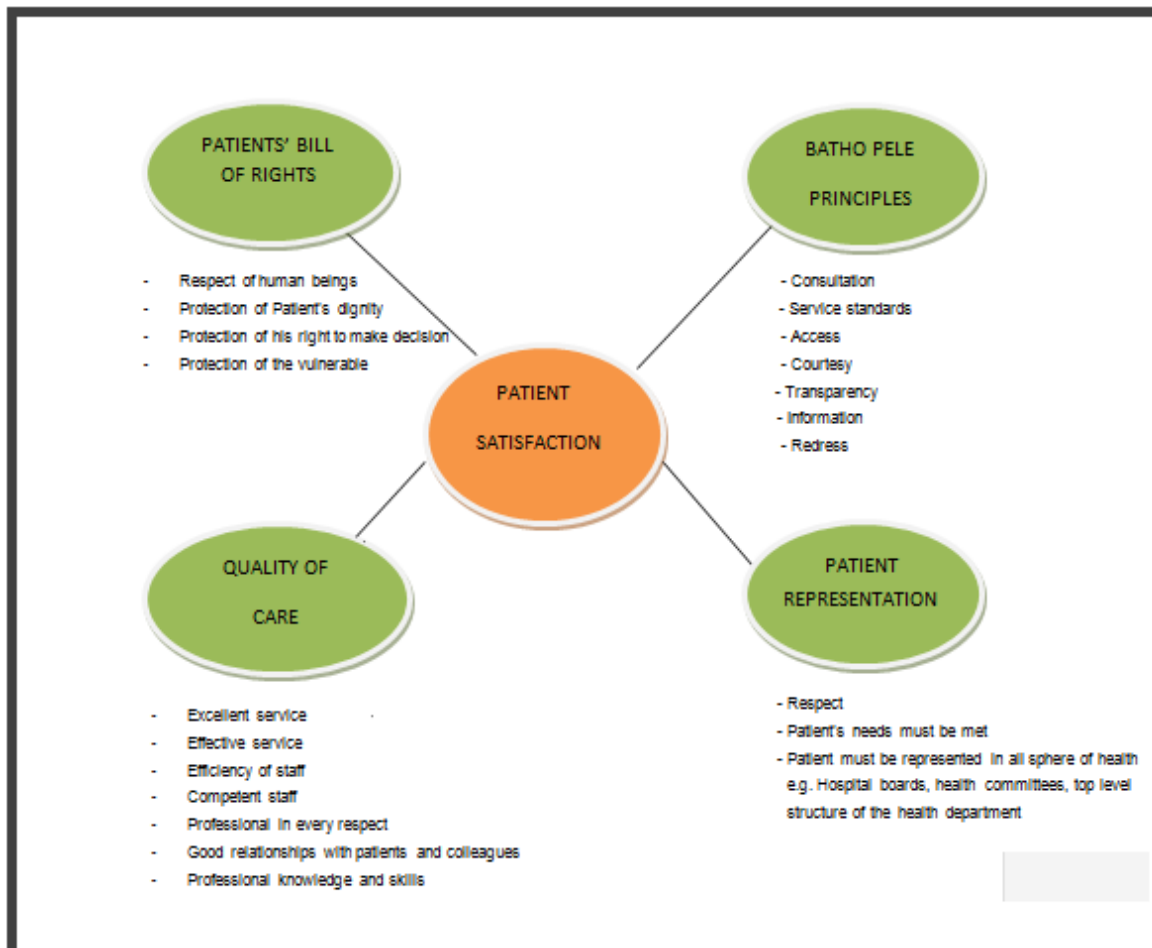
Patients have an important role in the healthcare system and can give positive information about accessibility and effectiveness of healthcare provided (Haddad et al., 2000: 21-29). Ahmed and Din (2010: 95) see the patient opinion as being a true reflection of the quality of healthcare delivery received, as the patient is the best judge of quality of care delivered. Haddad et al. (2000: 21-29) add that the information from patients can be used to evaluate the services rendered to patients and help to improve health care delivery. This is also supported by Chandwari et al. (2009: 25) who recommend that health authorities should use patient satisfaction surveys as a measurement of health care outcomes.

The South African Department of Health's strategic framework for 2002-2004 identified improvements of quality care as one of four key challenges of the Health Sector in the country; and quality of care is determined by interaction between the health services and the community (Department of Health Core Standards, 2006:14-24). The Core Standards of the Department (Core Standards, 2006:14-24) emphasised that the implementation of quality improvement programmes is necessary to safeguard patients against negligence.

The weakness of set standards initiatives (aimed at assessing, ensuring and improving health) should take into account the service users' level of satisfaction or experience of care after using the health service while the Patients' Right Charter must to be used to ensure patients' rights are adhered to (Core Standards, 2006: 14-24).

## 2.6 Conceptual Framework

Concepts are linguistic labels that we assign to objects or events (Brink et. al, 2006: 25) and they are the building blocks of theories (Brink, Van der Walt & Van Rensburg 2012: 27). Theoretical frameworks for research are based on the propositional statement, resulting from an existing theory (Brink et. al, 2006: 19). The conceptual framework for this study with the key concepts is illustrated by Figure 2 below.



**Figure 2. Conceptual framework for study**

The conceptual framework includes the following concepts:

- Patient Satisfaction;
- The Patients' Bill of Rights (South Africa, 1996: 3);
- The Batho Pele Principles (South Africa, 1997: 12);
- Patient Representation; and
- Quality of Care.

For the purpose of this study these five concepts have been linked and related to each other. At the centre is the concept of **Patient Satisfaction**, which is dependent on recognition and adherence to the four concepts of **The Patients' Bill of Rights**, the **Batho Pele Principles**, **Patient Representation** at the level of reception of health care and delivery of **Quality Care** ensured by health care providers.

The concept of patient satisfaction is defined as the consumer's views of the services received and the results of the treatment received (Ibrahim, 2008: 14). Patient satisfaction as a goal is only achieved when the other concepts which are part of this conceptual framework are applied. The Patients' Bill of Rights and Batho Pele Principles are legislatively enforced by government to be applied by health workers and government institutions when dealing with patients.

The Patients' Bill of Rights calls for respect for human beings, protection of patient dignity, protection of patients' rights to make decisions, protection of their vulnerability and of their rights to have access to health care. The Batho Pele Principles were developed to ensure that effective service delivery is in place to meet the basic needs of all South African citizens. They also emphasise the need to consult with the client to be able to deliver the necessary services.

This aspect introduces the next concept of the conceptual framework for the study, namely Patient Representation. Patient Representation is achieved when a patient's opinion is sought about the services received. This opinion is used to improve service delivery so that Quality of Care is perceived. Previously this opinion was obtained from health committees which were part of the running of CHC and clinics in South Africa, on which the patients had representation. The cornerstone of democracy is that citizens have the right to voice their opinions openly and be involved in decisions that affect their lives (Dennil, King & Swanepoel, 2003: 81-82).

The first three concepts describe patients' rights. The last concept of the conceptual framework is Quality Care which adds the idea of excellence to services rendered. The patient not only has a right to have access to services, but they also have the right to have access to services that are of a satisfactory standard. When quality of care is ensured, patients will have an improved health status and thus also a better quality of life, with resultant satisfaction about services. Quality of care is dependent on the staff rendering the care, and the feedback systems that exist to determine whether the care was perceived as being excellent.

### **2.6.1 Patient Satisfaction**

Patient satisfaction is an important parameter in the assessment of the quality of a healthcare facility and includes respect for the patient and understanding their needs and providing services accordingly (Umar et al., 2011:78; Lochoro, 2004:243; Alzolibani, 2011: 61). By considering what satisfies patients, the hospital's reputation in the community is positively affected (Aragon & Gesell, 2003: 229).

When users of health care are involved in the care the outcome and the satisfaction levels improve. Compliance and continuity of care also improve. Patient satisfaction needs to be measured frequently so that health care plans could be developed and evaluated to improve the service according to what the patient wants and needs. Satisfaction is experienced when the patients are happy with the quality of care received (Al Sharif 2008: 20, Ahmad et al., 2010: 95). Any industry that is interested in quality outcomes will value customer satisfaction, because satisfied customers are loyal customers (Dalal & Dawad, 2009). Waiting time can be used as a measurement tool for patient satisfaction or dissatisfaction.

A complete definition of patient satisfaction should take into account the following ideas:

- The consumers' views of services rendered and treatment received (Ibrahim, 2008: 1);
- A general orientation towards a total experience of health (Doherty, 2003: 10);
- Dignity and respect shown to and experienced by patients (Chaka 2005: 3); and
- A desired outcome of care as an important parameter in the assessment, designing and managing of quality care (Alrubajee 2011: 104; Naidu & Umar, 2009: 2011).

Patient satisfaction is central to the delivery of services to patients and should be the main determinant of successful output of services. When the patient is satisfied with the service rendered, health care service is regarded as being of a high standard. Positive appraisals and positive comments by patients give the staff and management strength, pride, high morale and satisfaction. Satisfaction amongst staff is followed by decreased levels of stress and frustration and high staff morale. When patients are satisfied the CHC's image improves and more patients want to make use of it, and this results in improved health behaviours (Alrubajee, 2011: 104).

Lack of positive feedback thus inversely results in negative experiences for staff, which in turn impact negatively on the way they deal with patients, and in the long-term on how the community perceives services rendered at and the overall image of the CHC.

Patient satisfaction reflects on the quality of technical and non-technical work provided by the health care provider. Technical expertise includes all the procedures that are carried out on the patient and the availability of the equipment used, including adequate health professionals to cope with the load of the patients. Non-technical elements and expertise include the attitude of staff towards the patients even when they work under pressure. Batho Pele Principles are designed so that the health professionals put the interest of the patients first before their own.

The literature, however, shows that patients generally are not satisfied with the services rendered to them by health care providers globally and the main reason is waiting too long for services (Afolabi, 2003: 214; Liabsuetrakul, 2012: 22).

### ***2.6.2 Patients' Bill of Rights***

The constitution of the Republic of South Africa, Act No.108 (South Africa 1996: 13) guarantees to the citizens the right of access to effective health care services. The Patients' Bill of Rights was adopted in 1999 as a common standard of practice for the nursing profession for achieving the realisation of the rights of patients to access health care services. The constitution indicates that the state must respect, promote, and fulfil the rights of individuals in the Bill of Rights (South Africa, 1996:30). The National Health Bill defines the rights and responsibilities of both health users and health care providers (Khoza, 2009: 15).

Ethics, professional practice methodology and standards of care taught at basic nurse training level are centred on the rights of the patient to knowledgeable, legal and ethical care. The quality of health care delivered and respect displayed by health care workers and information given by them to the patients should be appropriate (South Africa, 1997a: 13).

Muller (2008: 6-7) mentions that the Patients' Bill of Rights protects the patient in various ways: respecting them as a human being and as a person, protecting their dignity, privacy, vulnerability (when they are unable to protect themselves due to lack of strength, will or knowledge), and safeguarding their rights to access health, emergency and rehabilitative care within the organisation. The patients have the following rights as prescribed by the Charter:

#### *A healthy and safe environment*

Everyone has a right to safe and clean environment which will result in physical and psychological well-being. Overcrowding and bottlenecks experienced in the CHC (Du Plessis, 2008: 103) may create an unhealthy environment as patients are close to one another. Patients come to the health care centre with different illnesses and there is a high risk that they may infect one another. The waiting and bottleneck contributes to mental anxiety and distress especially for chronic patients who are at risk of developing complications due to this stress.

#### *Participation in decision-making*

Patients have a right to take part in decisions regarding their health; when no or few doctors are available they should be able to decide whether to stay or balk, with the necessary input from staff about the situation at hand. It is important for patients to be included in the decision making processes so that they contribute to issues affecting their health (Chaka, 2005: 3) and input in evaluating of services.

#### *Access to healthcare*

This right gives the patient access to emergency care, treatment and rehabilitation and an explanation of care. It compels the health care providers to explain the availability and use of health care services and in a way that addresses patients with dignity, empathy and tolerance and in a language understood by them. There is no proper access if a patient has to balk due to long lines and without information provided or if a

patient is standing in the wrong line or has to wait for a displaced file before service can be delivered.

#### *Treated by a named health care provider*

Health providers should wear a name badge so that patients know who is addressing them. They need to know who the officer is that regulates the flow in the CHC and whom to complain to if services are less than satisfactory. Not knowing whether they will see the doctor with whom they have an appointment can also cause a perception of disrespect with a patient as displayed by staff.

#### *Confidentiality and privacy*

A patient's private information may only be used by their informed consent. Patients' folders are confidential and staff should keep close control over these. If a patient perceives that his folder is lost in the system, this can cause severe anxiety, especially if he has potentially compromising health information in his file, like a positive HIV status.

#### *Informed consent*

The patient has the right to full and accurate information to be able to make informed choices. This pertains also to treatment, information about medicines available or not available on specific days due to waiting, lack of stock or staff in a CHC. As the service providers are often too busy to spend time explaining these issues to patients, this aspect often gets neglected.

#### *Refusal of treatment*

A patient may refuse treatment as long as it does not endanger others. Balking can be done if the line is not moving. With some patients, like diabetics, this could be the necessary route as they may need to eat. By not communicating about the status quo of the movement of the queue, staff is not providing patients with this option.

#### *Referral for a second opinion*

Patients have a right to a second opinion. If not enough doctors are available to provide for referrals and second opinions, this poses a problem towards meeting this requirement.

### Continuity of care

Health care providers are responsible for the treatment of from the beginning to the end. If folders are misplaced or the patient is not seen by the same staff member then continuity of care is at risk as the history of previous treatment is not at hand.

### Complaint about health care services

All patients have the right to complain about a health care service and have their complaint investigated. Listening to and addressing the patients' complaints and following up on them is important to the complainant. If these are ignored, the patient will feel especially aggrieved.

### **2.6.3 Batho Pele Principles**

The White Paper on transforming Public Service delivery prescribes to service deliverers to put people first. The Batho Pele principles reflect on the need for effectiveness in delivery of services to meet the basic needs of all South African citizens (South Africa, 1997: 22). The term "Batho Pele" is Sotho for "People First" (Muller, 2008: 8). The following are the Batho Pele Principles:

#### Consultation

Public service should consult citizens about the level and quality of care (South Africa, 1997: 22). If there is any problem about the level and the quality of care to be delivered, the users should be informed and an explanation given.

#### Service Standards

The standards for the quality of care must be relevant and meaningful to the user, be specific and measurable (South Africa, 1997: 22). The service standards must be displayed and users must be able to evaluate and complain if these standards are not met.

#### Access

All citizens, especially the previously disadvantaged, should have equal access to health care (South Africa, 1997: 22). Equal access also means the ability to see the doctor if needed, and not having to balk because of a long queue.



### Courtesy

Citizens should be treated with courtesy and consideration. Health care services must ensure that the public is treated as a client who is entitled to good service. They should be properly addressed, the health worker should be identified, and there should be a procedure in place for dealing with complaints. Patients must be treated fairly as individuals, with empathy and consideration and in an unhurried manner (South Africa, 1997: 22). The later list of aspects is lacking according to the literature, especially in areas with overworked and overburdened staff that are being perceived as very rude by patients.

### Redress

Citizens should receive an explanation and an apology, if services cannot be delivered properly. Complaints should be addressed speedily and with empathy (South Africa, 1997: 22). Consumers of health care do not experience this principle often.

### Information

Clients should receive full information about the services due to them so that they can understand which service is necessary for them to receive (Muller, 2008: 8-9). The principle on the provision of information aims to empower patients to understand the health care services they are entitled to receive, their illness, diagnoses and treatment and if any problems exist in delivering the service timeously.

### Transparency

Citizens should be told how national and provincial departments are run, how much they cost and who is in charge (South Africa, 1997: 22). The service provider must be open in keeping and giving up to date information to the customers. Explanations about hold-ups in the queue and reasons why services are slow and when patients could expect to be seen should be communicated.

### Getting value for money

The services should be cost effective, procedures simplified, waste and inefficiency decreased and delivered within allocated budget (South Africa, 1997: 22). The onus is on the management of a CHC to see to these administrative issues and to ensure that

the government is getting value for money as seen by health outcomes like patient satisfaction and quality of care perceived.

#### **2.6.4 Patients' Representation**

From the beginning of South Africa's still young democracy it was required that patients had to be represented in all the structures of the health care services to be able to give them an opportunity to be involved in decisions affecting their future and to determine whether services are appropriate and effective. Community participation in health care delivery is a process of interaction between people which shows respect for people's opinions and experiences and is a basic requirement for the attainment of optimal health of the community (Dennil et al., 2003: 81-82). Patients have a right to take part in decisions regarding their health; when no/few doctors are available, they should be able to decide whether they stay or balk with the necessary input from staff regarding the staffing situation, and their complaints and concerns should be heard as also spelled out in the Patients' Right Charter and in the Batho Pele principles.

Patients' definitions of their health care priorities and evaluation of their care received accordingly is necessary for evaluation of health care outcomes. The extent to which the consumer can influence policy makers and health care personnel depends on the willingness of the policy makers and health staff to accept the customer's views. It also depends on the willingness of policy makers and health personnel to accept the value of the consumer's point of view. Policy makers have made their wishes clear and it now depends on management to change their approach from that of facility centred to a patient centred.

#### **2.6.5 Quality Care**

'Quality' has two dimensions in service delivery according to Chakraborty and Majumdar (2011: 151): a technical dimension which **is the core** service provided and a process dimension which include **how** the service is provided.

Muller (2008: 200-202) sees five dimensions to quality that corresponds with the six of Ovretveit's (2009: 8):

The manager needs to recognise certain characteristics of excellence which include:

- Making the right decision at the right time (Muller, 2008: 200-202) **to** reduce long waiting times and harmful delays (Ovretveit, 2009: 8);
- Ensuring a therapeutic environment (Muller, 2008: 200-202), **and safety from** harm from care that is intended to help them (Ovretveit, 2009:8);
- Provision of health care services, facilities, equipment and expertise, personnel (Muller, 2008:200-202 and **effective** services provided which are based on scientific knowledge that produces clear benefits (Ovretveit, 2009: 8);
- Appropriate risk management, knowledge and competency (Muller, 2008: 200-2012) and **efficiency** in avoiding waste at all times (Ovretveit, 2009: 8); and
- Satisfaction of patients/families (and patient-centred care to ensure staff is respectful and responsive to individual needs and values and services are equitable) (Ovretveit, 2009: 8), management, doctor, nursing practitioner, and other team members (Muller, 2008: 200-202).

Quality care refers to the attributes of excellence. There are two main players in the health field with quite different agendas regarding the meaning of excellence to them: the patient and management of health care. Health care personnel attempts to please both players, but serving two masters are an impossible task, with resultant fall-out and burn-out.

**The patient** expects only the best nursing care possible. The patient wants equal and fair treatment and expects his rights as a patient to be protected (Muller, 2008: 199-200). Grondahl (2012: 8) mentions that patients' experiences with quality of care and patient satisfaction in hospital are important elements to improve quality in hospitals and indicates quality healthcare. Grondahl (2012: 8) adds that patients who are satisfied will have better adherence to treatment and thus have better health outcomes.

**Management of health care** expects that the nursing care will be delivered cost effectively and efficiently with minimal legal liabilities. Adequate use of scarce resources also forms an important part of managements' view on quality and excellence rendered. Clinical excellence and effectiveness of nursing in its entirety is expected by management.

To address the problems of having two masters, the Scottish National Health System had implemented successful strategies and priorities ensuring caring and compassionate

staff and clear communication and explanations about conditions and treatment (National Health System Scotland, 2010: 1). They focus on the following points:

- Putting people at the heart of the National Health System by listening to people's views, gathering information about their perceptions and personal experience of care **and use the information to further improve care** (NHSS, 2010: 5); and
- Their strategy to attain quality care includes making explicit the connection between the **patient priorities and the values of the people** working for them.

## 2.8 Application of Queuing Theory

When Queuing Theory is applied to the Vanguard CHC situation in relation to waiting time, one has to take into consideration the population served in the area and the numbers of staff, servers and stations available at the CHC. The key points to be considered are:

- Population of the community in relation to healthcare facility;
- The staff component;
- Head counts of patients in relation to staff component;
- The number of servers in relation to the number of patients served; and
- Stations that the patients go through.

### *2.8.1 Population of the communities in relation to healthcare facility*

The communities that are served by Vanguard CHC are those of Langa and Bonteheuwel. They are bordered to the North, West and East by a railway line and to the South by the N2 Road as shown in Figure 3 below.

These two communities have a population of 93,552. Vanguard CHC is the only 24 hour health care service for both communities and also receives patients from the adjacent areas which are drainage areas for Vanguard CHC. The surrounding areas also use Vanguard CHC after hours, as other CHCs operate on an 8 hour shift during day time only. Some of the people from the settlement areas (squatter camps), for example Joe Slovo in Langa, have moved to areas like Delft but still prefer to use Vanguard CHC for service as they are familiar with its operations and its staff.

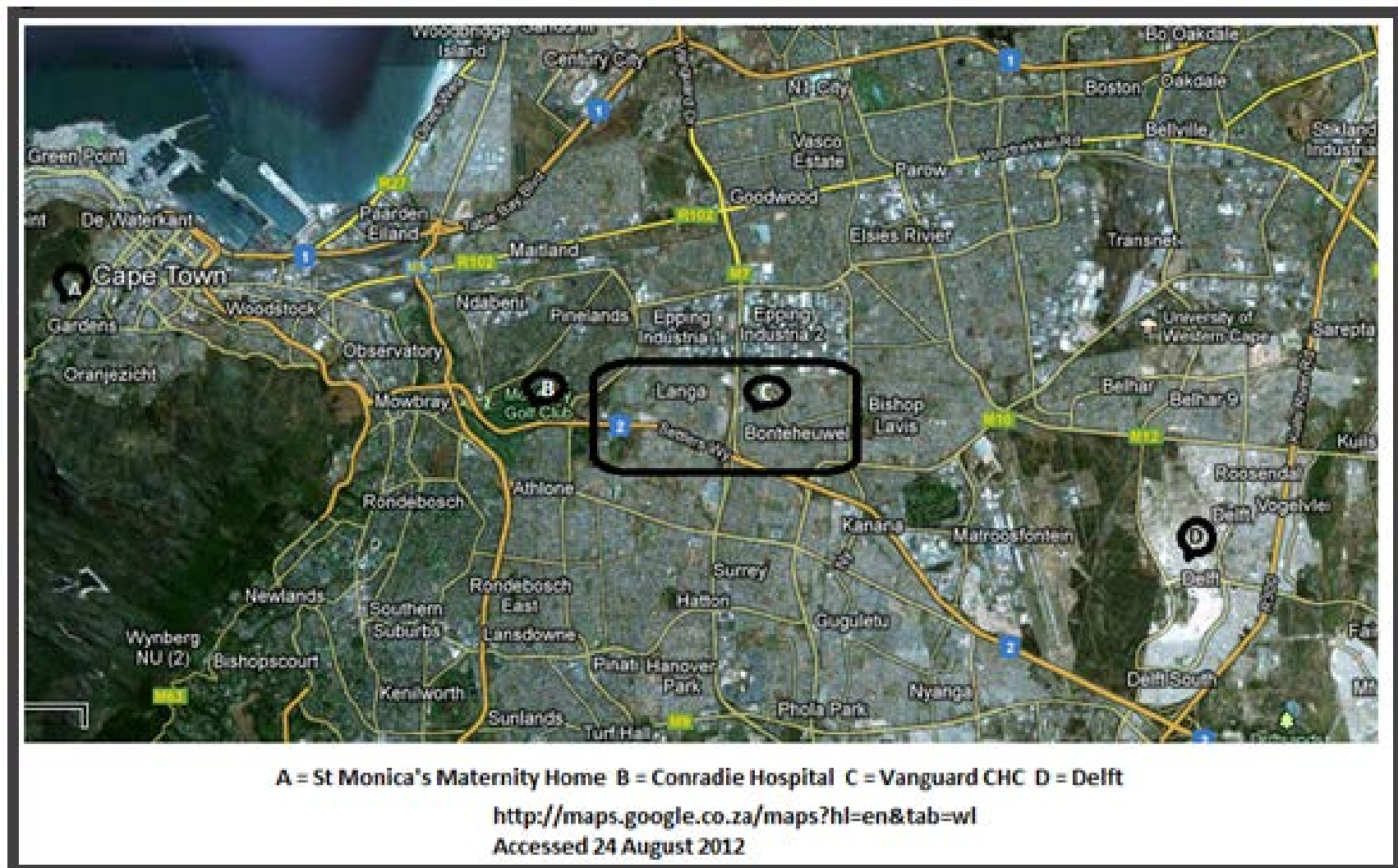


Figure 3. Map of the Catchment area of Vanguard CHC

### 2.8.2 Staff component of Vanguard CHC

The total number of staff members working at Vanguard CHC is 136 as the breakdown in Table 1 below shows. This includes day and night duty personnel.

UNIT	FUNCTIONARY	STAFF NR	TOTAL
<b>Administration</b>	Facility Manager	1	-
	Administrative Officer	1	-
	Logistic Clerk	1	-
	Human Relations Clerk	1	-
	Health Information Clerk	1	-
	Secretary	1	-
	Helpdesk Officer	1	-
	Porter	1	8
<b>Nursing</b>	Operational Manager	3	-
	Chief Nurse Professional	12	-
	Senior Professional Nurse	8	-
	Professional Nurse	12	-
	SASO	1	-
	Senior Nurse Enrolled Auxiliary	13	-
	Enrolled Nurse	7	-
	Enrolled Nurse Auxiliary	16	-
	H PO	1	-
	Data Capturer	1	74
<b>Dental</b>	Dentist	1	-
	Dental Assistant	1	2
<b>Medical doctors</b>	Family Physician	1	-
	Principal Medical Officer	2	-
	Senior Medical Officer	2	-
	Community service medical officers (Cosmos)	4	9
<b>Reception</b>	Receptionist In-Charge	1	-
	Clerks	11	-
	Data Capturers	1	13
<b>General Assistants</b>	Housekeeper	1	-
	General Assistant	16	17
<b>Pharmacy</b>	Pharmacist	2	-
	Pharmacy assistants	5	7
<b>Radiography</b>	Senior Radiographers	4	-
	Student Intern	1	5
			136

**Table 1. Staff component of Vanguard CHC**

The staff at Vanguard CHC comprise of personnel from the previous Langa CHC, Bonteheuwel clinic, St Monica's Maternity Home, and some of the trauma staff from Konradie Hospital. Langa and Bonteheuwel both demanded a 24 hour service, as previously they had to travel to hospitals like Groote Schuur for trauma and emergencies which were too far away from them. Therefore the need for a 24 hour hospital was prioritised by government. These communities also claimed to be the oldest townships in the Western Cape and felt that compared with newer areas, like Khayelitsha with a 24-hour service, they were treated unfairly.

Thus, the Vanguard CHC was built to serve the communities of both Langa and Bonteheuwel. To meet the criteria for a 24 hour service, the population statistics of both these two communities had to be combined. Initially, only the day hospital staff of Langa and the managing authority (Department of Health) was involved in the planning. Later, the authorities decided to include the local government of the City of Cape Town and its Bonteheuwel clinic in this 24hour service. Subsequently, through negotiations by the government with the Anglican Church and management from Konradie, St Monica's Maternity Home in Bo Kaap and Konradie Trauma from Konradie Hospital joined. Staff from Langa Day Hospital, Bonteheuwel clinic, St Monica's and the Trauma Department of Konradie hospital moved to the new Vanguard CHC building in April 2000 to form the new staff component of the new Vanguard CHC. Table 2.4 above illustrates the staff establishment at Vanguard CHC as it is currently.

Initially, some of the concerns of the Langa and Bonteheuwel communities were that they would lose their Langa CHC to the Bonteheuwel population. Bonteheuwel clinic staff also resisted to join the other groups, possibly due to fear of the unknown. The government then made the decision to build a 24 hour trauma/emergency hospital in Bonteheuwel as part of the Vanguard CHC.

Currently the patient/nurse ratios at the Vanguard CHC are far from ideal. If compared to the adjacent drainage areas in the bigger Cape Town area, a gradual increase in numbers of patients are seen over the years. Average monthly headcounts of all patients, including those on chronic medication, seen at Vanguard CHC total 27555.3, and on a daily basis translates to an average of 918.51.

### **2.8.3 Number of servers in relation to the number of patients served**

There is only one server (mainframe computer) for the CHC. There are six computer stations at the reception area that should register patients, of which only one computer is functioning properly. Most of the time the computers are down and this causes a delay in registration of patients. An average of 919 patients needs to be seen on a daily basis. These patients go through different stations and different services at the centre as seen in Table 2 below.

### **2.8.4 Stations that patients go through**

Patients come randomly or consistently in singles and in batches. They generally prefer to come early as they hope to be able to be seen first and then leave early. In most cases this does not happen. This pattern of arrival causes overcrowding, long queues and delays as mentioned by Jooste et al. (2011: 1) in the literature review above. Some patients are booked to see the doctor or get their medication, have tests done, whilst others are not booked.

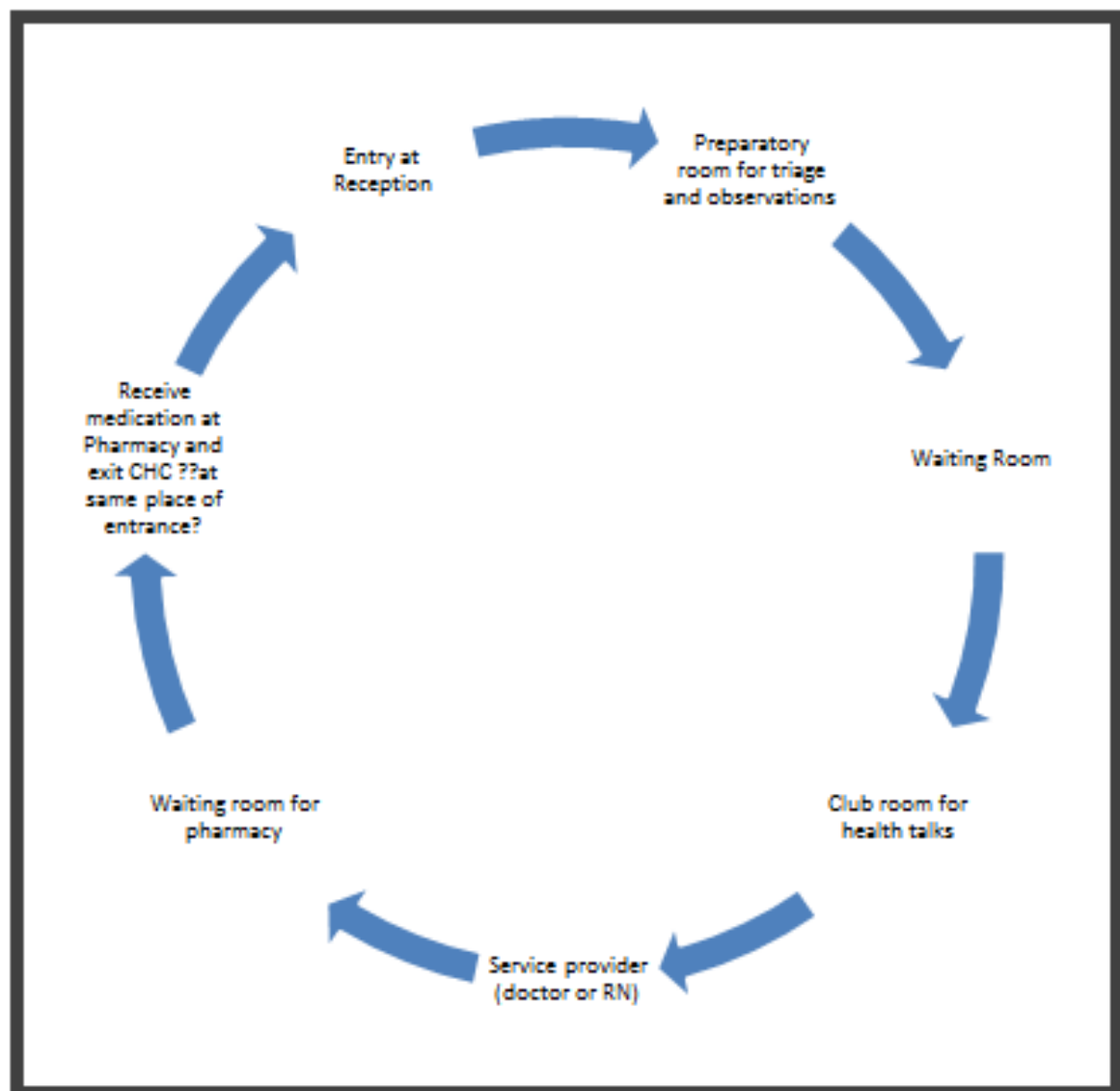
There are several stations that the patients have to go through before they are seen by the doctors or clinical nurse practitioners and can exit the CHC. Table 2 below shows the different stations and services patient can make use of in Vanguard CHC.

<u>MOU</u>	<u>Day Hospital</u>	<u>Trauma</u>	<u>ARV</u>
Preparatory room	Preparatory room	Medical emergency	VCT
ANC	Rehabilitation	Trauma	
Delivery room	Mental health	Triage	
Post Natal	TB		
PMTCT	Child health		
	Reproductive health		
	Management of chronic illnesses (club)		
	Dressing room		
	Injection room		
	X-Ray		
	Dietician		
	Oral health		

**Table 2. Service stations available in the Vanguard CHC**

Thus, patients spend quite some time at the CHC. Below, Figure 4 shows the CHC flow for chronic patients.





**Figure 4. General flow of chronic patients at Vanguard CHC**

When comparing the number of patients registered daily with the staff component available and the total population of both communities, an imbalance is seen. This imbalance translates to a shortage of staff to serve the population and results in frustration and dissatisfaction of patients seeking nursing and medical interventions at the CHC.

## 2.9 Discussion

Findings of local and global studies about the phenomenon of long waiting at health care centres show the same trends: intolerance towards long waiting times by the users of these services. The level and type of service rendered influences the amount of waiting that takes place. At primary health care level, waiting takes place in the form of queues for triage purposes to determine which service is needed by the patients. At tertiary level one waits for an appointment date to see a specialist. In the private sector patients often have to wait for approval from the medical aid insurance to have certain medical care. Problems experienced by patients in having to wait long for health care services are a challenge to both health care providers and management globally. The literature review has shown that long waiting for healthcare service causes dissatisfaction, especially to chronic patients who visit the community health centre frequently. Patients have expressed frustration and anger on visiting the community health centres due to these long waits.

The doctor and the pharmacist have been shown as the providers in the health care centre for which patients wait the longest. Studies also revealed that waiting is a result of serious shortages of staff, as well as freezing of essential vacant posts. This freezing of posts is a well-known way of management to cope with restrictions of their budget. This further negatively impacts on the remaining staff and the speed at which they have to serve the patients.

The conceptual framework adopted for the use in this study illustrates how Patient Satisfaction is dependent on application of the Patients' Bill of Rights, Principles of Batho Pele, Patient Representation and Principles of Quality Care. The Bill of Rights protects the patients in various ways especially when they are vulnerable and are unable to express themselves. The Bill of Rights also states that the patients have the right to complain.

The Batho Pele Principles were drawn up to assist the government in their effort to improve service delivery. There seems to be a discrepancy between that which is prescribed by law and that which is executed by the staff. The problem of waiting time for service should have improved if the principles of Batho Pele were applied. Health providers cannot claim they are improving services while patients still complain about

long waiting time at CHCs. One of the principles is redress, which states that if the promised standard of service is not delivered, the citizen should be offered an apology, and a full explanation and speedy effective remedy. Waiting too long for services has become the norm, staff and patients do not realise any more that it is not acceptable. It negatively affects the quality of care and health outcomes of patients.

Quality of care received is determined by patients after experiencing health care. The patient expects excellent service, which is achievable through competent, efficient, compassionate health providers who are patient-centred. The needs of the patients in such cases would be considered above everything else. In order to deliver quality of care, the conceptual framework of this study should be considered, as these concepts are interrelated; one cannot use one without the other. Waiting long for service will affect quality of care and patient satisfaction.

Patients' representation plays an important role in the delivery of service. The patients' views should be heard as patients have the right to take part in decisions regarding their health. Given this opportunity, both patients and management groups will be satisfied in terms of solving the problems as experienced by patients. Patients' opinions are necessary for evaluation of relevancy of services delivered and planning for future services to address necessary local needs. The patients should be allowed to define their own priorities and evaluate their care accordingly, rather than having those criteria selected by professionals. Consumers can influence policy makers and health professionals to accept the consumers' point of view and to change the policy makers' approach from a facility-centred to a patient-centred one to achieve patient satisfaction.

## **2.10 Conclusion**

This chapter dealt with the literature on waiting times and what consumers of healthcare have had to endure as a result of this problem. The literature review was used to build a conceptual framework that took to account the ideals and principles that the government envisaged for health service delivery. In the next chapter a discussion of the research methods for the study will follow.

## **CHAPTER 3**

# **RESEARCH METHODOLOGY**

### **3.1 Introduction**

In this chapter the research methodology used to determine the experiences of chronic patients about waiting time at Vanguard CHC is described. The research methodology of a study informs the reader of how the investigation was carried out and what the researcher did to resolve the problem or to answer the research question (Brink et al., 2008: 191). This chapter will contain enough detail to enable another researcher to replicate the investigation. The goals, objectives, research design, population sample, setting and gathering of data are described in detail (Brink et al., 2008: 191).

### **3.2 Goal of the Study**

The goal of the study was to explore the experiences of chronic patients of a community health centre in the Western Cape about long waiting time.

### **3.3 Research Objectives**

The objectives of the study were:

- To explore patients' feelings about long waiting time and
- To explore patients' suggested solutions to long waiting.

### **3.4 Research Question**

The research question identifies the variables or concepts that will be examined and often clarifies the focus of the study (Burns & Grove, 2003: 117). It is also a statement of the relevant query the researcher wishes to answer (Polit & Beck, 2006: 55).

The research question for the study was:

What are the experiences of chronic patients about waiting time at a Community Health Centre in the Western Cape?

## **3.5 Research Methodology**

### **3.5.1 Research design**

Burns and Grove (2003: 175-195) see the research design as an overall plan for conducting the research study that answers the research question and fits together information from various parts of the research. The design indicates the steps that will be followed and an attempt to control factors that could interfere with the validity of the study. The research design of this study is qualitative, with a phenomenological approach. Qualitative research focuses on understanding the whole and explores the complex phenomenon in depth, through the collection of rich narrative material through conversations between the researcher and the participant (Polit, Beck & Hungler, 2001: 211-215).

Phenomenological studies examine humans through the descriptions of their “lived experiences” in regard to certain phenomena. A phenomenon is that which is experienced directly rather than being conceived in the mind as some abstract concept or theory (Densombe, 2007: 76). A phenomenological approach enables interpretation of meanings that the participants attach to their everyday experiences (De Vos, Strydom, Fouche & Delport, 2005: 270).

With this study, the researcher gathered opinions of the participants through in-depth interviews that lasted for about 60 minutes. The participants were quoted verbatim in the transcriptions. These transcriptions helped to authenticate and classify the data. Subsequently the researcher was able to group the experiences of the participants in the CHC about long waiting time. The researcher managed through this approach to ‘bracket’ or set aside her own general and subjective ideas that health care staff usually have about patients to ponder the data objectively.

### **3.5.2 Population and sampling**

A population is made up of all the elements (individuals, objects, events or substances) that meet the sample criteria for inclusion in a study (Burns et al., 2003: 491). Sampling is the process of selecting a smaller group of individuals, objects, events, substances or behaviours which are representative of the population being studied (Burns et al., 2003: 496).

The researcher searched for a convenient sample, who was a particular kind of person that could illuminate the phenomenon under study (Wood & Haber, 2006: 90). Criteria for the sample in this study were therefore patients with chronic diseases of lifestyle who most often visit the CHC. According to the records of the CHC, the amount of patients with chronic diseases of lifestyle is (N=2928). A sample size of (n=12) was drawn for the study. A larger sample would have been drawn if new information came to light continuously. However, data saturation was reached in this study as the same information was heard repeatedly.

#### *Inclusion criteria*

Inclusion criteria for the sample were that the patients would have a chronic disease of lifestyle, (for example, diabetes, hypertension, asthma) and had visited the CHC regularly for more than a year to be able to comment on having to wait to be seen.

#### *Exclusion criteria*

Non-chronic patients and newly diagnosed patients with chronic disease of lifestyle were excluded as they might not have had to visit the CHC that much to experience problems with long waiting time. Children and pregnant mothers were also excluded as a vulnerable group.

### **3.5.3 Instrumentation**

Instrumentation for this study consisted of one-on-one interviews with a semi-structured guide (as seen in Appendix A). The interview is a method of data collection frequently used in exploratory research where an interviewer obtains responses from the subjects encountered face to face, as this is the most direct and best method of obtaining perceptions and facts, values, preferences, interest tasks, attitudes and beliefs (Brink et al, 2006: 151).

In qualitative studies, the interview format is open-ended. The goal of the interview is to obtain an authentic insight into the participant's experiences (Burns et al, 2003: 376). The researcher also used her observations to compliment the reported experience of the subjects as part of the instrumentation, as she also works in the facility and is knowledgeable about the phenomenon under investigation.

Tape recordings were done during the interviews to allow the researcher to concentrate on the respondents during the interview and review the spoken words afterwards. The interview questions were relevant to the topic. The interviews were conducted in isiXhosa and English, depending on the patient's choice of language.

#### **3.5.4 Pilot study**

During the pilot study, one patient with the same criteria of the population was interviewed to determine if the questions needed to be modified. The questions were found to be relevant and the researcher proceeded with the same semi-structured interview for the study participants.

#### **3.5.5 Validity testing**

Validity seeks to address whether the measures used by the researcher yield data that reflects the truth of the statements of the participants. (Brink et al., 2006: 163). Validity also entails that the instrument should measure what it proposes to measure, namely experiences of chronic patients about waiting times, and not another topic about attendance at a CHC.

The semi- structured interview was based on the objectives of the study and validated by the supervisor and specialists from the nursing department of Stellenbosch University during a proposal presentation. It was screened and found acceptable by the Ethical Committee of Stellenbosch University.

Data was transcribed from the audiotaped interviews and the transcripts and audiotapes were screened by the supervisor and the translator to validate that the data was representative of what the participants said.

De Vos (2005: 346) proposed that credibility, transferability and conformability are alternative constructs to validity in qualitative research.

#### **Credibility**

The literature search covered the prevalence of waiting time extensively on the global platform. The researcher then gained information from the interviews of the participants regarding waiting time in the CHC and compared this with the data in the literature review

and in the conceptual framework to determine the relevance of the data to that which is already known about the subject.

Massive amounts of data were gathered like this. Reflection was done on the emerging themes and discussions with the supervisor and other experts in the field to gain clarity and understanding of the phenomenon of waiting time amongst the users of the CHC (Brink et al., 2006: 184-185). Sub-themes were identified as the researcher immersed herself further in the data and re-read the material thoroughly. These themes and sub-themes related to the research question of what participants experienced to be causes for long waiting, as well as the solutions to the problem. The researcher then compared the written interviews with each other to find themes and categorize them to be able to determine patterns.

### Transferability

Transferability is the extent to which the findings from the data can be transferred to other settings or groups. Qualitative research finding cannot be generalised easily (De Vos et al., 2005: 352). The questions posed in this study can however be used to conduct a similar study in another similar setting, which if yielding the same results, will have implications for change in the way community health centres deal with their patients.

### Dependability

Dependability is the criterion to establish trustworthiness of the study (Brink et al., 2006: 119). De Vos et al. (2005: 352) states that for the research to gain trustworthiness, an external reviewer will examine the study so that it can be replicated. The Xhosa speakers' recorded and translated data was checked against the English transcripts by a Xhosa-speaking translator to determine authenticity. The research supervisor further verified the themes and sub-themes that were obtained from the participants by also listening to the audio records and comparing the English-speaking participants' audiotapes to the notes.

### Conformability

Ulin, Robinson & Tolley (2005: 168) recognise the researcher's central role in defining issues to be studied, interpreting information, and guiding the research process. They



believe that when one is conscious of one's own subjectivity, one can better understand and limit its effects on research activities from data collection to analysis, thereby allowing participants to express their experiences without constraints. Interpretation, conclusions and recommendations should be a true reflection of the data collected and not figments of the researcher's imagination or her or his perspective on the situation (Brink et al., 2008: 119). The supervisor's and translator's verification of the information obtained through replay of the audiotapes also confirmed the interpretation and conclusions of the researcher.

### **3.5.6 Data collection**

The chronic population under study were informed of the research project in the waiting room where they were waiting to be seen by a consulting doctor or clinical nurse practitioner, or for procedures. The researcher explained that the interview would be used as a data collection tool, and that they would need to provide signed consent forms when they agreed to be part of the study. Patients were requested to volunteer to do the interview and it was explained that the duration of the interview would be approximately one hour. The first twelve participants (n=12) that volunteered over a couple of days were interviewed, and they did so freely. Most of them did not need to be probed to give their opinion during the interview. They were informed of their rights beforehand and requested by the researcher to sign the consent form to show that they are willing to take part. Data were collected in such a way at the CHC during August 2011.

Semi-structured interviews were used as a method to collect data and to obtain responses from the subjects on a face-to-face encounter by the researcher. The interviews took place in a consulting room at the community health centre, which was quiet and private and kept the identity of the participants anonymous.

The interviews were exploratory and descriptive and were conducted in isiXhosa and English, depending on the patient's language choice. Interviews focused on answering the research questions, aims and objectives. Probing was used to increase detailed explanation, elaboration and more in depth information on the subject's attitude on waiting time. Recordings were done to ensure that no information was lost due to the researcher writing notes when interviewing.

The participants were coded by numbers and not by names to ensure confidentiality. The data is stored in a safe at the residence of the researcher of which only the researcher has access to. The records of the interview and tape recordings will be kept for a period of 5 years and will be discarded in a secure way to ensure privacy and anonymity.

### ***3.5.7 Analysis and interpretation***

The data analysis process included all the relevant notes, recordings, demographic information and participants' information. The data was in the form of written words and audio tapes. ). Massive amounts of data in this form were gathered, reflecting on the possible meanings and the relationships of the words (Brink et al., 2006: 184).

The researcher analysed the words by listening to the tapes and transcribing the respondents' recorded interviews. The data were then explored in detail for common themes which were codified into units. The verbal responses of the researcher's notes and the transcribed interviews were captured into a master file on a "Microsoft Word document" immediately after each interview. Non-verbal cues were noted in a diary and were recorded. A colour code index with highlights of phrases was used to identify different themes.

Examination of the words, expressions and emotions were monitored during and after each interview (Brink et al., 2006: 184). Memos about the context and variations in the phenomenon under study verified the selected themes. Reflection on the data and discussions with other researchers or experts in the field was done. Categories were refined and recording of support data for categories and identifying propositions followed. The researcher checked the reliability of the coding by having another person encode the same data and then checking for agreement (Brink et al., 2006: 185).. The content of each unit was categorized, from those categories themes and patterns were developed. Once the data was categorized, an independent expert checked it to ensure accuracy and appropriateness.

### ***Familiarisation and Immersion***

The researcher immersed herself in the data and became familiarised through multiple readings of transcribed notes, discussions with the supervisor and clarification and comparing with the emotions heard on the tape. It was important that the researcher

attempted to determine the beliefs of the participants as well as those that the participants did not verbalise (Terre Blanche, Durheim & Painter, 2006: 322-323).

### Inducing themes

The themes arising from the data was grouped into specific categories. The themes should arise naturally from the data and should have a bearing on the research question (Terre Blanche et al., 2006: 324-326). Six themes were found within the data coded and each had at least two sub-themes. These themes and sub-themes are mentioned in chapter 4 and discussed in chapter 5. Themes had a direct bearing on the research question and the researcher was able to answer the query posed as will be discussed in Chapter 4 through the themes and sub-themes found.

### Coding

Coding is the process in which data was broken down to be analysed. Data was broken down into meaningful pieces that belong (Terre Blanche et al., 2006: 324-326) to themes and sub themes to be able to make sense of all the information and interpret it properly.

### Elaboration

Elaboration is exploring themes more closely to capture hidden data (Terre Blanche et al, 2006:326). The data was re-examined for more subtle themes that might have been overlooked. Interpreting pieces of information was obtained when the data was re-examined and brought more insight of how patients experienced the CHC, some problems apart from the waiting time was also identified.

### Interpretation and checking

Checking interpretation is done by discussing it with other people who are familiar with the topic and to people to whom the topic was unknown (Terre Blanche et al., 2006:326). The researcher compiled a written account of the interpretations that emerged from the data analysis and verified this with an expert in this field as well as with the supervisor.

### **3.5.8 Ethical considerations**

Permission from the ethics committee of the University of Stellenbosch was obtained to conduct the study through their acceptance of the research proposal. Permission was also obtained from the health care facility where the research was conducted.

The way the patients were recruited also helped to ensure that participants became involved in a totally voluntary way, as they had to come forward after the purpose of the research was explained in the club room where chronic patients were waiting to be seen. Before participation, they had to decide whether they had an hour to spend on an interview to give their opinions. After they presented themselves to the researcher and were found to qualify according to the inclusion criteria, each was given a participation information leaflet with a clear explanation of what the study entailed and a written consent form was completed. The participants signed this consent freely. Consent was also obtained on this form for the use of a tape recorder. Participants were assured of anonymity and that information would not in any way be connected to them personally when feedback and recommendations were given to healthcare management. They were also ensured that secrecy about their participation would be maintained at all costs by the researcher and that the information they volunteered would be totally anonymous and would not have negative consequences for them in the future. The participants were also informed that they could withdraw at any time from the study if they so wished and that they would not be penalised in the event that this should happen.

### **3.6 Conclusion**

This chapter dealt with the goals, objectives and the design of the study. The chronic patients of the CHC were the population of the research, and a sample of the more regular visitors was used to obtain the data. The next chapter will describe how the data was analysed and what findings were obtained.

## **CHAPTER 4**

### **DATA ANALYSIS AND INTERPRETATION**

#### **4.1 Introduction**

This chapter discusses the results of the study of the experiences of chronic patients about waiting time at Vanguard CHC in the Western Cape as obtained from interviews during 2011.

Data analysis in qualitative research involves making sense out of text, moving deeper and deeper into understanding the data to be able to interpret it (Creswell, 2009: 183). Commonalities and differences are found in the interviews and then grouped into themes and sub-themes and categories of meaning for interpretation and accurate representation (Wood & Harber, 2006: 93). Empirical evidence through the senses was obtained by listening to the patients' words, watching the emotions at play when they described the predicament of having to wait too long for services. Inductive reasoning was used to combine all the evidence and to come to conclusions about the meaning and dilemma of the phenomenon.

The steps for data analysis as proposed by Terre Blanche et al. (2006: 322) were described in Chapter 3. Familiarising and immersion with the material collected, clarification of themes, coding, and elaboration of the themes and checking of the results against interviews were followed. The data is presented in two sections. Section A explains the biographical data obtained from each interview. In Section B each theme and sub-theme that emerged is described. To ensure privacy of the participants, each participant was assigned a number when data was analysed, thus participants were not referred to by name to ensure confidentiality.

#### **4.2. Biographical Data**

The participants' relevant biographical data will be listed in this section.

##### **4.2.1 Age**

The sample consisted of (n=12) and the participants' ages ranged between 46-70 years.

The majority (n=11) were between the age of 60-70 years, and one person (n=1) was 46 years old.

#### **4.2.2 Gender**

There were (n=12) participants of which, (n=7) were females and (n=5) were males.

#### **4.2.3 Employment**

Of the (n=12) participants, (n=11) participants were pensioners and (n=1) was unemployed and disabled. This indicates that most of the patients with chronic diseases of lifestyle of the sample are older people. This characteristic of the sample corresponds with the general trends of both the Langa and Bonteheuwel communities..

#### **4.2.4 Type of Chronic condition**

Out of (n=12) participants, (n=10) participants had hypertension, (n=1) had asthma and (n=1) had diabetes mellitus Type 2.

#### **4.2.5 Culture**

Culturally the participants were equally divided between the two populations of Langa with mostly African heritage (n=6) and Bonteheuwel (n=6) with mostly mixed cultures collectively known in South Africa as 'Coloured'.

#### **4.2.6 Means of transport**

Half of the sample (n=6) used public transport like a bus or taxi to get to the CHC, while the other half walked to the CHC.

### **4.3 Themes that emerged from the interviews**

Six main themes were explored during the interviews and are discussed as main themes

- Causes of long waiting time at the CHC
- Areas of concern where bottlenecks occur
- Communication from staff about long waiting period
- Effects of long waiting on the patients
- Emotions that arose from long waiting
- Proposed solutions to long waiting.

Several sub-themes emerged from the six major themes. The six themes and their sub-themes are displayed in Table 3 below.

<b>THEMES</b>	<b>SUB-THEMES</b>
<b>Causes of long waiting time</b>	Overcrowding
	Improper planning
	Shortage of staff
	Uncaring staff
<b>Areas of concern where bottlenecks occur</b>	Reception area
	Doctor's consulting rooms
	Dispensary
<b>Communication about waiting by staff</b>	Mixed communication
<b>Effects of long waiting time</b>	Poor control of chronic disease
	Non-adherence
<b>Emotions that arose from long waiting</b>	Frustration
	Feeling sick
	Unhappy
	Not welcomed
<b>Proposed solutions to long waiting</b>	Decentralisation of chronic medication dispensing
	Organisational planning
	Proper supervision of staff
	Competent and efficient staff
	Recruitment of staff

**Table 3. Themes and sub-themes found in data**

Causes of long waiting time as the **first** theme isolated include the sub-themes of overcrowding, improper planning, shortage of staff and uncaring staff. The **second** theme that emerged was the areas of concern where bottlenecks occurs the most. These areas were identified as reception, the doctors' consulting rooms and dispensary. Communication about having to wait long by staff to the patients was the **third** theme identified. The results here were varied as there were mixed experiences amongst the participants.

The effects of long waiting time as the **fourth** theme included sub-themes such as poor control over chronic diseases and non-adherence. The **fifth** theme of emotions that arose from waiting too long had the sub-themes of feelings of frustration, feeling sick, unhappiness, not feeling welcomed. Proposed solutions to long waiting time as the **sixth** theme included sub-themes such as decentralising of dispensing of chronic medication, good organisational planning, recruitment of health care professionals, competent and efficient staff and proper supervision of staff.

These themes and their sub-themes will now be discussed in detail below.

#### **4.3.1 Causes of Long Waiting Time at a Community Health Care Centre**

Participants spoke openly about their experiences of the causes of long waiting time at the CHC. The most common causes expressed by patients were overcrowding, improper planning, shortage of staff and uncaring staff.

##### **4.3.1.1 Overcrowding**

The participants mentioned that one of the causes of long waiting time was overcrowding. This was what participants had to say:

**Participant 1** said, *The clinic is always full of people from all these places, they come to the clinic because some of them were staying in Langa, but now they had moved to other places, so that is why we have got a long wait of people.*

**Participant 7** responded by saying, *It is overcrowded and you think you will get home earlier because you have an appointment, but it doesn't work that way. People even pay other people to fetch their medicines and these people turn up any time of the day. Everyone knows that when you attend the day hospital they must be up early. But they also know it's not a good thing to sit there all the time*



*from early in the morning early till late in the afternoon to be told “we are out of medicines, you must come back in two days’ time.*

**Participant 11** mentioned that *there is a lot of people, the clinic it’s handling more than it’s supposed to The day I go to the clinic, then I always prepare myself. I know I won’t come out of there quick, I don’t make other arrangements (for the rest of the day) when I go to see the doctor.*

Most participants commented that the clinic was always full. People from the surrounding areas of Khayelitsha, Gugulethu, and Mfuleni with their own health care facilities still use the Vanguard CHC as preferred facility. Participant 1 explained the reason for this being that these people previously lived in the catchment area of Langa, and now lived elsewhere, but still used the CHC.

Overcrowding resulted in long waiting time and patients end up leaving late at the CHC. This overcrowding was in line with findings of the Queuing Theory; patients were arriving randomly, alone or in batches to the health care facility and this resulted in queue formation. The system of making appointments also does not seem to shorten waiting times as anticipated by staff and patients as they still go home late.

These results correspond with Jooste et al. (2011: 1) and Benjamin & De La Harpe’s findings (2011:25) that clinics were already congested and overcrowded early in the morning at the point of entry (reception), with queues formed and patients experiencing long waiting time as a result.

#### 4.3.1.2 Improper planning

According to patients, ineffective planning by the managers and inefficient staff seemed to be affecting the service delivery at the CHC. Participants mentioned patients queuing in wrong queues and also the misfiling of folders. Participants also complained about the doctors that start too late. Participants showed resentment when they had to sit and wait the whole day for service.

Comments included the following:

**Participant 6:** *There are too many people throwing other people’s hospital cards away. Participant 6* also added that, *‘...when you come to the hospital you find*

*that they can't find your folder and this is another thing why the waiting time is so long.*

One respondent mentioned coming at 07H00 only be seen at 12H00, and then:

*... when we at last come to the doctor, it is said that doctor is in the meeting and when doctor comes back from the meeting, it is said that...it is time for them to go off duty, and then we have to come back another time, although we have been there already, as it was our given appointment.*

This participant mentioned *...I think the whole system is not right; us with diabetes, when do we eat? We have not eaten all that time.*

Deep resentment was evident when participants mentioned that they know that they had to come early, but still had to sit there from the morning to the late afternoon. This resentment were palpable with the statement: *it's not a good thing to sit there...coming from...the morning early and leaving late in the afternoon and sometimes...you are told 'we are out of medicines', you must...come (back) in two days' time.* Another participant felt resentment towards fellow patients that did not come early and then flooded the system when they arrive. They realised however that not everyone could sit and wait the whole day for a service.

One participant was careful about apportioning blame to the staff and mentioned the preparation time that is needed to see patients as a reason for having to wait for services:

*... all that [waiting time] depends with the people working there. We could not judge that these people are not doing their work properly. The staff must have time to prepare for the patients; you don't just go in and get on duty. You collect things to be used at that moment so that takes time. Sometimes things are not here they haven't got enough material you have to go to the store room to get things.*

People seemed to be confused about which queue to sit in as this respondent reported:

*Most of the people there do not sit in the right queues.*

The result was they had to sit and wait longer for the confusion to be sorted out. One participant specifically mentioned not feeling well because she had to move from bench to bench. It was mentioned by participants that people do not understand how the system functions and some reported that their expectations of being first in and then first out was not being met. They questioned the fairness of the system and blame it on lack of discipline or authority.

**Participants 6** response had to do with inefficient staff: *there are too many people throwing other people's hospital cards (away). This participant adds: When you come to the hospital you find that they can't find your folder and this is another thing why the waiting time is so long.*

These results correspond to the findings by the Health Information System (2012: 1) which also commented on the lack of efficiency in the management and staff. Findings by the Canadian Health Coalition (2009: 2) also support these results of poorly organised services causing inefficiencies and lack of coordination among all those involved in delivering services. Mgijima (2010: 23) confirmed that the patients wait in wrong queues and spending a long time before accessing service.

#### 4.3.1.3 Shortage of staff

Most participants recognised shortage of doctors and nurses and commented that more staff needed to be working at the CHC. One participant said that this situation impacted on how participants saw the nurses: *...it seems like nurses are not doing their work, because of few doctors...* but stated that she knows that they are actually doing their work in the background.

Participants mentioned shortage of staff as the most common reasons for long waiting time. Most participants reported shortage of doctors as the reasons for long waiting time. The participants reflected the need for more doctors and more staff at the CHC, saying:

**Participant 1:** *the clinic is short staffed; there are few people who are working there. We need more people, because there are a lot of people from Langa, Khayelitsha that is why we need more people, more staff to work at the clinic.*

**Participant 2** also mentioned lack of doctors as contributing to the problem, saying that, *We observe that there are lot of nurses but there are few doctors. I don't know whether they can't find them (doctor) to work here.*

**Participant 8** agreed saying, *I don't think there is sufficient doctors there early in the morning I get there at about 06H30 then I can only get help here after 09H00.*

**Participant 3** identified the reasons for long waiting time as a lack of nurses and complimentary staff:, *The reason for long wait is shortage of nurses and even other type of staff needs to be employed.*

Participant 4 and 12 also agrees with Participants 1 and 3 about the shortage of staff.

**Participant 4's** response was, *The reasons for long waiting time are that, we wait the whole day for tablets. Another reason is shortage of staff, they must employ more staff.*

Participants mentioned shortage of staff as the most common reasons for long waiting time. Shortage of staff as reason for waiting long was quoted as being the result of staff that had to treat patients from other catchment areas. There were varied responses as to what category of staff were short, with general consensus about too few doctors, others mentioning that nurses were short, while others said there were plenty around. Some considered the possibility that doctors were not easy to come by. This could possibly have been a reflection on the need for an appropriate budget to supply them. Others did not wonder where they would come from; they just thought that more staff had to be employed. Evidence from the interviews showed was that there was no effort perceived to employ more doctors after complaints raised.

The problem of long waiting time was confirmed by Steyn et al. (2005: 244) in the literature when mentioning the seriousness of staff shortages, major budget cuts and freezing of posts as major problems of long waiting time at healthcare facilities. Benjamin and de la Harpe (2011: 29) also confirmed that clinics are understaffed, resulting in other areas such as pharmacy and doctors consultation rooms not functioning on time. Turkson (2009: 68) also mentioned inadequate, overworked staff that cannot produce good and satisfactory results. Breier (2008: 11) added that a

shortage of doctors in South Africa is a critical matter and stated that the situation is even worse in the rural areas.

#### 4.3.1.4 Uncaring staff

Another cause for long waiting time is uncaring staff that caused patients to wait long for service as stated below:

**Participant 1:** *Sometimes we wonder, it seems to us there is no authority in this hospital or discipline or they don't attend to us. It is as if we have to come here and beg them to help us.*

**Participant 10** responded by saying, *When the personnel is coming in the morning we are already waiting for them. They come and greet each other, hug each other and then they have conversation. We sit and wonder when are they going to start to work or come to interview us or ask us anything and then we take notice that they do as they please.*

**Participant 10** added, *Sometimes they send us to another window, as if you are a fool.*

One of the participants (Participant 8) felt that the staff does not have any respect for the patients, and remembered when he was told to “go sit down” when he enquired about his folder. He was then called only half an hour later, to be taken care of.

Participants revealed lack of respect, ignoring patients, rude, uncaring staff and lack of supervision. Turkson, (2009: 68), Tshabalala (2002: 27) and Lutala et al. (2010) shared the same view with the results, that health workers were perceived as rude, unfriendly, unapproachable, uncaring, having a poor attitude and did not respect their patients.

#### **4.3.2 Areas of concern where bottlenecks occur**

Another theme that emerged from probing of the participants during the interviews was the problematic areas where bottlenecks and an unacceptable long waiting were observed. Participants shared the same views about where they waited the most and for the longest periods. These include the reception area, the doctors' waiting room and the dispensary. Two participants also mentioned having to wait at the observation area, the injection/treatment room and the 'blood-testing' area.

#### 4.3.2.1 Reception

The reception area is the first point of entry at the CHC and participants experienced bottlenecks in this area. This is what the participants had to say:

*The first problem is at the window, where you put the card in the morning and then they sent you back [to sit and wait]. They say: 'go and (we) will come collect the cards.*

He also says: *They sent you from one window to the other widow.*

Another participant added,

*To me the starting point is the problem and after this, obviously the next area will be at the doctor, because if the starting point starts wrong... all the other areas will be affected and by the end of the day the people [waiting] at the pharmacy are so frustrated... So the starting point is the main thing. So I do believe that by addressing the problem as the starting point the whole hospital will have a better service delivery.*

The organisation at the reception area has been questioned as one participant said that there should be two rows, one for new people and one for chronic patients. The problem is that the chronic patients have to stand in the same row as the new people, causing them to wait long and often having to come back the next day. Another confirmed this situation of distress where they had to share the same row, even though they only wanted medication. Comments were also made about patient files that do not go to the doctor in numerical order as patients arrived. Staff had been found to take up to an hour to look for missing files

This participant is thus of the view that if reception staff could attend to patients without delay, then no problems would be experienced in other stations. This notion is supported by the Queuing Theory that says the queue is like a river flowing without forming reservoirs; if it does form reservoirs, problems would be experienced with the lack of flow of the queue (Hall, 2006: 36-41).

#### 4.3.2.2 Doctor's rooms

The lack of communication about the doctor's movements is another cause of great frustration: *"some doctors go to tea and then we have to wait for them"* instead of the staff putting these files with another doctor. Another mentioned the University of Cape Town's student doctors leaving early and then there would be no-one to replace them. A patient commented after being told that there is no doctor: *"this makes you very disappointed, as you are there for your appointment to see the doctor, there is no reason for this, as this is a hospital and there should be doctors"*.

Another patient comments on staff rushing them along the system and that they were told to tell the doctor, *"just tell him you want your tablets"* so as to not hold up the queue. There are also issues about the ability of some doctors that are able to see more than others: *"some doctors see a lot of patients"*.

The doctor's consulting rooms were indicated by half of the sample as a place where hold-ups took place. Some reported having to wait 5 hours to be able to see a doctor eventually. Some reported that there are not enough appointments available and therefore they could not see a doctor when they were really sick and needed him. They experienced that doctors were scarce, that they are there for a short while only, and that they also had other duties, like going for meetings. A shortage of doctors over the lunch time was also reported.

Some participants confirmed their experience of being rushed through the system when they state that they do not get examinations when necessary at the doctor. Another participant states that chronic patients who should see doctors every 6 months, do not manage to do so. More chronic patients are seen by nurses this way as should be allowed, as the arrangement is that these patients would only need to fetch their chronic medication or see the registered nurse every month, but they also need to see the doctor at least twice a year (every six months). Generally participants experienced that there is not enough time to see them.

#### 4.3.2.3 Dispensary

The dispensary or pharmacy is the last point where delay takes place: *"At the medication... maklik sit jy daar tot more"*. Participants that complained about the overcrowding also mentioned that they have had to wait hours when they have only

came to fetch their chronic medication. Often after waiting in the queue through various service points during the day, they arrive at the pharmacy to hear; *“Come tomorrow to fetch medication...”* or *“...we are out of medicines...”*

One participant said: *...by the end of the day the people waiting at the pharmacy are so frustrated that you are blaming the pharmacy staff for being slow and delaying the people waiting to go home.*

Participants have mentioned that a pharmacist refused to give out any medication due to the din in the waiting area. This patient felt extremely resentful towards the pharmacist because of this action, and was willing to use racial and religiously slurring terms to describe him by. This was an otherwise reasonable man that used to serve on community health committees previously, that felt so disempowered and utterly victimised.

According to participants it does not matter that you come early; you still wait till the end of the working day. Having appointments does not help at all; there are still delays to receive your file, to be seen by the doctor and to get medication at the dispensary or to get treatment like an injection. Bottlenecks and constraints in any part of the service system cause patient flow obstruction and delays, interrupting natural flow and hindering movements along the care pathway (Gallagher, 2005: 5). Benjamin et al. (2011) confirmed that patients spent lengthy periods in unpleasant conditions at community clinics, and overcrowding was more noticeable at the reception area.

#### **4.3.3 Communication by staff about waiting time**

One participant explained that sometimes communication does takes place, but that it depends on the particular staff member:

*They are not all the same, some are nice, they will tell you that there are no doctors. Some of the staff explains to us that there are no doctors, and that they are short staffed.*

Some said that communication takes place only when there are few doctors. Another participant adds that there is communication, but only after waiting a while, thus not consistently, indicating that there is a need for on-going communication, not only about the shortage of doctors, but about the general flow and expected delays.



A large contingent of the participants denied that they had ever encountered communication between staff to the patients about the topic of having to wait for a long period. Their severe denial indicates some insult experienced about having to wait so long without at least an explanation. The following extracts from the interviews underline this issue:

*... nobody explains...*

*... you see staff coming in and out, but do not know what is happening...*

*... we wait till late to be called...*

*... they do not treat us as human beings...had to ask them how they could treat people like this...*

Mixed reactions were experienced by the participants about communication by staff to patients about having to wait for a long time. Reactions varied about staff that is very polite and realise that the patients do not want to stay there all the time, to staff that is very unpleasant and doing just as they please when asked what the status quo about waiting is. A participant mentioned that is difficult for staff to communicate as they do not know the plans of doctors. Another mentioned that patients also need to listen carefully to hear announcements. There seems to be a lot of talking amongst patients to pass the time, with the result that some patients do not hear or do not understand communicated messages from staff. This results in patients shouting at staff and wanting everything at once.

These reactions are an indication that there is communication, but that it is not consistent and there is a great need for this type of communication so that patients can have an idea of where they are in the system and for them to make a decision about staying or balking.

#### ***4.3.4 The effects of long waiting time***

Although patients had general complaints of feeling physically sick and having pain from complaints as a result of waiting, some have resigned to be patient. Reports of people leaving without their medication were also received. Some reported that they missed their transport and had to walk home after their visit.

One participant emphasised the fact that staff have to be on the lookout for people that become sicker in the waiting room, and need to attend to such emergency cases first. Impact on their chronic condition from having to wait too long was plentiful as reported to the researcher.

#### 4.3.4.1 Poor control of chronic illnesses

A significant amount of participants reported the effects that long waiting time had on their blood pressures:

**Participant 6** said, *I am a heart patient and also a high blood patient. If we are sitting so long it sometimes makes your... blood pressure go up and because you get frustrated, it also causes a pain over my chest and instead of going to hospital for help you (become) sicker than ever.*

Another participant mentioned that he starts the day off well, but that waiting long increases his blood pressure. This caused even more anxiety as he now worries about the comment the doctor is going to make on his blood pressure reading (and possible compliance to taking of medication).

**Participant 7** narrated that, *You go from the house... your blood pressure is low and when you get to the hospital and you wait such a long time, by the time you get to the doctor... your blood is high ...from waiting, and... you think...what is the doctor going to say now (as) I'm all anxious for waiting such a long time.*

One participant had to be seen because *"his blood was pumping"* (referring to a high blood pressure) and he was feeling sick because of this.

**Participant 8** also confirmed the frustration experienced when waiting long for service:

*Look you get tired from sitting the whole day, I don't have lunch, I have breakfast at home, now I must wait till almost 16H00... (to) get home in the afternoon. That's a long wait and I'm tired and then there's nobody to bring me back and I've got to walk from the hospital back home again.*

**Participant 1** also reported having to be seen after *"feeling sick"* because of increased blood pressure.

This length of stay at the CHC causes catastrophic results to specific categories of chronic patients, especially the diabetics, who suffer from hypoglycaemia (or starvation as it was put) without food or from hyperglycaemia if they did have access to food but not to their chronic medication. One such patient reported headaches, a runny stomach, becoming extremely hungry, falling asleep in the queue, forgetting where she was in the queue (confusion).

Hendershot et al. (2005: 35) mentioned that when clinics are managed inefficiently, increased stress levels, frustration and anxiety will be experienced by patients, resulting in uncontrolled chronic diseases.

#### 4.3.4.2 Non adherence to appointment dates by staff at CHC

One participant commented:

**Participant 9:** *The chronic is more or less the same as other people. They (are) sitting there (and waiting and) get tired, they (are) moaning and groaning. Some people get up and walk out and don't come back.*

One participant mentioned that the appointment for reception of the repeats of medication is at 08H00, but they will only get medication at 14H00. This means that though the patients are making appointments to get their repeat medication this is not honoured by the pharmacy staff, as the patients were told to come the next day.

Patients also reported non-adherence to fetching chronic medication due to not wanting to wait for medicine or a doctor or not wanting to return and wait for treatment not yet received. Decroo et al. (2011) found that long waiting time experienced by patients was reported as the reason for default.

#### **4.3.5 Emotions evoked during waiting long at the community health centre**

The emotions experienced, whilst waiting long at the CHC by the participants were: frustration, feeling physically and mentally sick, feeling unhappy, and not feeling welcomed. Some raised concerns about how they are treated by health care workers as discussed below.

#### 4.3.5.1 Feeling physically and mentally sick

A diabetic participant was concerned with the fact that waiting too long was affecting her physically; the last time she had something to eat was early in the morning before coming to the CHC. This caused her blood sugar to drop. She continued to say,

*Even if I bring myself something to eat to hospital, I must share with the person next to me, as that person does not have anything to eat and she is also hungry.*

This caused further anguish – having to see that others are hungry and are suffering because of having to wait so long. A participant also mentioned that having to watch other patients and their distress while waiting herself caused her to feel physically sick – especially when observing teenagers that are pregnant and youngsters that come in from street fights with bullet and stab wounds.

Participant 6 expressed feeling of frustration and unhappiness. Participant 6 continued to comment that the hospital is there to help but the waiting actually impact negatively on their health.

**Participant 1:** *...at one stage they had to come and see me because my blood pressure was pumping (high) It makes (me) not feel good.*

#### 4.3.5.2 Feeling unhappy

The hospital is there to help the patients, but it can cause more frustration and health problems due to having to wait so long. Participants mention the disappointment they feel when being treated like this, feelings of physical and mental tiredness. They report that the only reason they still wait while experiencing these feelings is because they do not have a choice.

During the interviews the researcher observed strong cues of despair, anger, sadness and depression as expressed by the participants' tone of voice. They placed great emphasis on their negative experiences about having to wait so excessively. Feelings of helplessness were expressed with comments like, *"Please help us."* (Participant 2 and 3), and several participants used the word 'tired' when asked how they felt. Participant 7 added that, *"Well it makes me feel disappointed..."*

Hendershot et al. (2005: 35) also confirmed that clinics are managed inefficiently; this causes increased stress levels, frustration and anxiety experienced by patients. Lengthy patient waiting time is a source of frustration as well as a source of dissatisfaction for patients and families resulting in uncontrolled blood pressure.

#### 4.3.5.3 Not welcomed

One participant felt that the staff ignored them when they were chatting and hugging each other, and this made her feel unwelcome. Another participant echoed this feeling: *"You feel (such) as a person who is not welcomed, you are even tired"*. This comment indicates that staff was perceived as being uncaring, unsympathetic and showing no empathy towards the patients watching them socialise in a situation that was fraught with frustration for the patients. There seems to be no idea amongst the staff that patients feel resentful, or there does not seem to be anyone caring if the patients seem resentful. The disempowered patient seems to be the norm accepted by the CHC. Lutala et al. (2010) shared the view that health workers were perceived as rude, unfriendly, unapproachable, uncaring, having a poor attitude and did not respect patients.

#### 4.3.5.4 Frustration

Feelings of frustration were expressed which resulted in severe unhappiness and resentment because the CHC is there to help but the waiting experienced there actually impacts negatively on people's health. Resentment tends to erupt at the last point of waiting, particularly at the pharmacy as the last point of contact with the by now very frustrated patients.

#### **4.3.6 Proposed solutions to problems of long waiting time**

The problem was seen as the responsibility of government to resolve and to render the necessary adequate services. Participants mentioned that the dispensing of chronic medication should be dealt with in another way to take the burden off the CHC so that chronic medication would be dispensed from elsewhere.

There was a suggestion that a place in the townships nearer to the people should be sought/built to dispense medication from, and that volunteers like matric dropouts should be used to help with this dispensing function so that they might be inspired to be employed in the medical or nursing field in the future after such a volunteer experience.

Most of the participants saw the solution to long waiting time as having to employ more staff. One participant commented that the solution would be for doctors to do home visits again, so that patients would not have to come to the CHC when sick. One participant suggested that,

*Government must employ people so that they can speed up the process. There is shortage, services are very poor, we are complaining.*

Another participant supported this statement, saying,

*The solution is to employ more doctors. There is no other solution; we do not see any improvement in the hospital as we experience the same problems all the time.*

The following are the major themes that emerged when asked about solutions to the problem of long waiting time at the CHC that had a direct effect on how the CHC functions.

#### 4.3.6.1 Proper organisational planning

Proper organisational planning is required for the services to run smoothly. Participants commented on the organisation of the CHC as not well planned. Addressing problems at the starting point was seen as a priority by a participant who recognised that problems at this point cause problems down the line.

According to comments from the participants, there were attempts at various methods to regulate the flow. Some mentioned an alphabetical system where people with surnames that came first in the alphabet were seen on some days, while those with the later letters were seen another day. An appointment system where chronic patients were asked to come at a certain time to fetch their medication was also discussed as having been tried but failing dismally.

Another participant saw the need to address waiting time at the doctors by looking at the following:

- Look at relieving doctors from some routine work, like signing of forms;
- Address the flow here, so that the doctor does not have to send the patient for another test and then have to wait for the patient to come back;

- Take the patient files to another doctor if the one you were allocated to do not have time to see you.

A lack of clarity on how the hospital system functions was mentioned and also that people were waiting in wrong lines. Patients do not understand the flow of the CHC system.

There were suggestions that only a certain amount of patients need be taken in per hour, with one participant mentioning 20 patients per time slot and another 40 patients divided by the doctors available at the time: *“I think if we can work out a better system. For instance there are five doctors, if they can split up forty patients for 08H00 (to be seen by the doctors).”*

Steyn et al. (2005: 23) stated that facility management plays an important role in actively implementing quality management and improved programmes. Proper organisational planning is required for the services to run smoothly. According to Hall (2006: 36-41) one of the solutions to long waiting time is a steady flow of patients to prevent patients accumulating in one section as confirmed by Queuing Theory.

#### 4.3.6.2 Recruitment of staff

Participants noticed the need for more doctors and nurses and ancillary staff. Their solution to the problem is to employ health care professionals in different disciplines, with more focus on doctors, nurses and pharmacists as these were mostly the groups noticed by most to be short in the delivery of their care and causing them to wait long.

#### 4.3.6.3 Competent and efficient staff

Committed, competent, efficient staff is needed that will put the interest of the patients above everything else as per Batho Pele Principles and the Patients' Bill of Rights.

Several participants mentioned that they present themselves early but get seen much later in the day, even though they have an appointment for a certain time. This indicates a lack of efficiency—patients not having the staff's attention while staff members are busy with something else such as administrative or preparation work (Health Information Systems, 2012: 1).

Several participants mentioned that folders go missing or gets misfiled. This has the effect that duplicates need to be made without any previous history or knowledge of a patient's disease. This takes the health care provider longer because he has to obtain a new history of the patient and his treatment.

Good planning with commitment and support by management brings about quality and consistency in service delivery (Tshabalala, 2002: 16).

#### 4.3.6.4 Proper supervision

When staff socialises in front of patients instead of attending to them, participants read this as a lack of authority or discipline at the CHC.

A participant remembered attending another health care centre where the manager of the hospital spoke to her staff severely because of a lack of attention to patients. This person obviously saw a person with these qualities as a role model for the CHC staff. He also mentioned some staff as being able to address complaints, but had a big problem with the rest of them that did not help those that could not stand up for themselves. He mentioned that he had had to negotiate several times for some patients to receive the necessary attention from staff. He also commented that he was a previous member of the old Health Committees that existed as part of ensuring the patient input in the health care centres on primary level. He commented that he had family members currently in the medical field and that this problem of lack of management seems to be less of a problem in secondary and tertiary health care institutions, quoting Groote Schuur hospital as an example of a hospital rendering good care.

Suggestions were made that staff needed to know that there is authority watching the service rendered, so that they realise that they need to work hard and not stand around with folded hands. Authority was needed to look into matters. There was a need for them to walk amongst the patients and ask them if they were being helped, how long they have been waiting and what they are waiting for. A participant also mentioned that there was a help-desk officer, but that nobody knew who they were. Such a person needs to be more visible and needs to be identified by name and picture to be efficient, as it is done in banks and shops.



### **4.3.7 Discussion**

The goal of the study was to explore the patients, experiences about waiting time at the community health centre in the Western Cape. When these have been examined, solutions to the problems, with the help of patients' insights about the situation, can be addressed.

#### 4.3.7.1 Biographical data

Biographical data showed a good representation of the two communities served by the CHC, with their elderly chronic population of mostly pensioners expressing their thoughts on problems experienced and solutions suggested. Just over half of the sample was female, as is also reflected in the general population of South Africa. They suffered from the most common diseases of lifestyle which were asthma, hypertension and diabetes. Half of the sample lived near enough to walk to the CHC but the other half used buses and taxis. This latter group may come from outside the catchment area or further away from CHC.

#### 4.3.7.2 Queuing Theory

In the literature review Queuing Theory was identified as a method to describe the problematic flow of the health service in order to recognise the areas where flow is slow and to attempt to address the issues that cause this lack of proper flow of patients. A conceptual framework was also developed to understand and explain the participants' perceptions in the context of available legislative and quality requirements.

Queuing Theory can be applied very well in this study. Factors identified by the participants as causing delay in the flow of the functioning of the CHC were the following as explained per the four elements of this theory:

#### Arrival

Participants described the arrival of patients at the CHC as well planned from their side, starting from early in the morning before opening of the CHC as they expected to be seen on a first-come-first-served basis. Their expectations were not met, as every attempt of theirs to interpret the system and make it work for them are being thwarted. The CHC seems to function on the basis of a Fast Line, but there are many situations and factors which negatively affect the effectiveness of the solutions applied. As other

patients arrive randomly, single or in batches, with or without an appointment, some of whom need more urgent care or who manage to bribe staff, the whole system becomes blocked or interrupted to the frustration of those arriving early. It often results in them being the first in and the last out, as they have to wait at several points in the system (reservoirs formed).

### Queuing discipline

A queue is formed as patients enter the CHC, as they have to hand in their cards with numbers to be able to have their files drawn. At first the computer is not working to be able to register them. Another problem is that their files are missing or misfiled. As they are often inadvertently waiting in the wrong line, they also do not hear when their names are called. Many of them do not know how the system works and are not empowered to speak up for themselves, and thus waste time sitting in the queue at this point.

### Service mechanism

The number of service points that they are expected to pass through, and the number of staff available on a particular day are also detrimental to an easy flow through the system. A chronic patient has the most points to go through, and thus experience the most hold-ups at every one of these points where a reservoir can form, especially at the reception, the doctor's rooms and the pharmacy as mentioned by the participants. There is a large staff shortage reported at these service points, especially from the categories of medical doctors, nurses and support staff. This means that not enough servers exist to allow easy flow of patients through the CHC.

### Cost structure

The cost structure of the CHC is determined by the budget allocated to them by the Department of Health from the taxpayers' contributions. As South Africa's tax payers' basis is small because of high unemployment, a large number of users of public health services exist, putting a large burden on the budgetary resources of the CHC. Although the need for more staff is recognised by the participants, they do not have a realistic understanding of how freezing of posts impacts on their health service delivery, the staff that serve them, and the availability of medication, as well as the allotted waiting time.

#### 4.3.7.3 Patients' Bill of Rights

For the conceptual framework, four concepts were described as means to achieve Patient Satisfaction, and Patient Satisfaction was in turn the fifth and central concept of assessing the effectiveness of the health care service at the CHC. Discussions will focus on the perception of participants about reaching Patient Satisfaction with services at the CHC by looking at whether the concepts of the **Patients' Bill of Rights, Principles of Batho Pele, Quality Care** and **Patient Representation** are applied at the CHC, starting with the Patients' Bill of Rights.

Waiting time is a proxy for poor quality of care, and indicates poor management that affects patients health (Prentice et al., 2007: 6), and this is contradictory to the Patients' Bill of Rights Charter. The constitution of the Republic of South Africa, Act No 108 (1996: 13) guarantees to citizens the following rights: access to health; to a healthy and safe environment; to confidentiality and privacy; to informed consent; to a second opinion; to complain; to participate in decision making; and to refuse treatment.

Participants seem to have access to health care, but in such an unsatisfactory way that it negatively affects their health. Reports of uncontrolled blood pressures and blood sugar levels were received due to having to wait for too long. In these circumstances the environment cannot be seen as healthy or safe, as patients collapsed under the care of health care staff. Participants specifically asked in this study for staff to be more aware of what happens in the waiting rooms, so that they can render help in such an event. Confidentiality and privacy issues are a concern with files that go missing on a regular basis. Informed consent and the right to refuse treatment were implied to be absent by the participants reporting that they were not informed about what was happening, and thus did not have the choice to stay or balk; they could only stay and sit out the wait if they really wanted their chronic medication in order to control their disease. There were definitely not enough doctors to be able to get a second opinion, as a lack of doctors was the biggest problem of all those reported. Participants also mentioned that they did not see the doctor every 6 months, and that staff rushed them along, encouraging them to not report their health care complaints, so as to move through the system faster. The participants had no real awareness of their right to complain, but for one person who was previously a member of a Health Committee. He had exercised his right to complain, even though he was unhappy about the results. Their complaints, unhappiness and

frustration were obvious, but no one addressed these. A typical Hawthorne effect happened after the study, when one of the participants became aware of her rights, and demanded the next month from the researcher to be seen sooner, as she realised she had the right to do so.

One of the points of the Patients' Bill of Rights is the extent to which the users are treated with dignity and respect in the provision of care (Lochoro, 2004:244). It is noticed that the participants perceived that they were not treated with dignity and respect.

#### 4.3.7.4 Principles of Batho Pele

The transformation process to put people first is patient-centred and ensures that patients deserve the right to be treated with respect and dignity. It means that the patients must be informed and be knowledgeable about the eight principles prioritised in Batho Pele service delivery. Batho Pele principles are a departmental policy that is required to be implemented at all public institutions which are required to display them at their institutions at a place where patients can see and read them and know their rights. Both staff and patients need to know the contents in the Batho Pele so that each of these two partners can understand and implement it.

The participants in this study seemed unaware of these principles, even when asked about them in the interview. Consultation with the client of health care should be done to ensure that the quality of service they expect is in place. There is no evidence from the participants that this consultation takes place. There is evidence that they feel unwelcome, unwanted, and not a partner to this process. Service standards of quality are not being adhered to as evidenced by the complaints of participants as health care users in this study. This fact has been explicitly stated by some participants, when they verbalised that people are complaining in general about service delivery and long waiting.

Access, another Batho Pele principle, is denied to patients if services are so impaired; there is no flow, and patients have to be rushed along and be told that they should not complain to the doctor, as this will get them through the system quicker. Related to this, courtesy is severely lacking at the CHC as displayed by the staff towards the patients, evidenced by the patients' perception that the staff is rude, unfriendly and unhelpful. The public service sectors are especially under an obligation to show courtesy to their clients.

With the principle of transparency the consumers of health care need to be told how national and provincial departments are run, how much they cost and who is in charge. However, participants commented that the whole system is illogical to them, and attempts to understand the flow of the CHC have been successful. They also have expectations of ideal staffing levels that are not comparable with what the legislators and management can supply. Management is also not transparent about service delivery, as budgetary restrictions and freezing of posts are not communicated to the health care consumers. Because of a lack of communication and information to the health care consumer, there is no realisation about procedures that are cost effective and delivered within the resource allocation. Participants see staff standing round and greeting each other as unhelpful and inefficient, and not contributing to the general idea that the Department of Health needs to get value for the money spent by employing them to deliver a quality service.

Batho Pele Principles also advocate that information is supposed to be given to patients about what is going to happen to them. In this instance, this also refers to communication about events and hold-ups and unavailability of doctors, so that an informed decision can be made about staying or balking, with consideration of own personal circumstances. Participants of this study reports a lack of this type of communication.

The principle of redress was not being adhered to as participants were able to all recount incidents where they had to wait without any explanation or apology. One participant was quite adamant that staff had to apologise and should feel ashamed about the way they deal with patients. There were several incidences reported regarding staff that were disrespectful to participants. Gill and White (2009: 10) stressed the point that the patient's judgement on the quality of care particularly relates to the interpersonal component of care.

According to Khumalo (2010: 1), Batho Pele is an initiative to get public servants to be service-orientated and to strive for excellence. Batho Pele has two primary functions: service delivery to the people as the customers and to hold individual public servants accountable for poor service delivery (Khumalo, 2010).

#### 4.3.7.5 Patients' Representation

Patients are generally viewed as passive beneficiaries of health care services and without a voice. The views and opinions of patients on perception of service quality and satisfaction with the health service can assist the management and policy makers in the design, implementation and evaluation of services to improve and deliver a quality health care service (Daniel, 2009: 75).

No evidence of patient representation has been observed from the data obtained from the participants. Although one participant mentioned that he previously was a member of a Health Committee, it seems that there are no longer such structures in place for the patients to voice their concerns and to give input about the services they would have. In such a body the Department of Health or management would also be able to communicate the restrictions they have regarding budgeting and staffing. In the absence of such a structure, the situation as it is gives rise to great dissatisfaction as evidenced by the general feeling of participants throughout the interviews.

If this inability to address the needs of the consumers of health care is ignored, it may have dire consequences for management and government. South Africa has had an unprecedented number of complaints about service delivery and people are striking to have their demands met. Apart from the fact that there is physical danger to the institution with the possibility of strikes, there is also the danger to the health of the health care consumers who would have even less access to their chronic care. It would serve management and the Department of Health well to heed these warning signs and attempt to open communication channels so that patients can be represented on the necessary forums or to make a significant attempt to hear and address complaints uttered by the consumers of their service.

Regular assessment of people's experiences ensures an effective functioning of the health care system (Shaikh, 2005: 1). Daniel (2009: 75) added that the views and opinions of patients on experiences of service quality can assist the management and policy makers in the design, implementation and evaluation of services to improve and deliver qualitative health care service (Daniel, 2009: 75).

#### 4.3.7.6 Quality of care

The Scottish National Health System (2010: 1) prioritised their strategies including caring and compassionate staff and clear communication and explanation about conditions and treatment. They focused on the following points:

- Putting people at the heart of the National Health System by listening to people's views, gathering information about their perceptions and personal experience of care **and use the information to further improve care** (NHSS, 2010: 5).
- Making explicit the connection between the **patient priorities and the values of the people** working for them.

The evidence in this study as provided by the consumers of the health care system of the CHC is that they do not have any say or understanding in

- how the service is run;
- what is going to happen to them on the day they turn up regarding service delivery;
- the length of time that they are going to have to wait for services;
- if they are going to receive any medication and/or treatment for their condition.

This reflects a totally disempowered situation for the health care user and thus a perception of no quality care received at all. Although the quality of care might be there as defined by the rigour applied by staff members to diagnose and treat, the inability of the system to flow satisfactorily causes so much resentment that this negates the contact with a service provider delivering the excellent care. This is an indication that service providers need to look at other ways to ensure client satisfaction, and that individual excellence in service delivery is not enough, and will only result in burn-out for the individual as nothing they do will be enough because the problem lies with the organisation of the system. Shaikh (2005: 1) mentioned that a quality health care system is seen as one that guarantees the continuum of care.

#### 4.3.7.7 Patient Satisfaction

Patient satisfaction is at the centre of interest for the researcher and this study. Adherence to the patient's Bill of Rights, the Batho Pele Principles, Patient Representation and Quality of Care are necessary elements to reach this status.

Patient dissatisfaction with the service is evident in this study about long waiting time. The answers to the questions in the interviews are an indication of severe frustration experienced by the respondents and reflect physical, emotional and medical deprivation due to long waiting time; some patients balk and others miss their transport or have to return the next day for treatment not available at the time. Although one patient sympathised with staff about how they had to cope, the general feeling were that they do not care and are rude. They do not seem to abide by the Batho Pele principles, and patients have no awareness of their rights within the Patient's Right Charter and the Batho Pele Principles, that they had recourse to Representation and a right to Quality Care. There are no measurements in place to determine patient satisfaction on a regular basis, as complaint boxes are not seen to nor is there a budget, will or ability to do something about the complaints.

As quality care is only perceived to be rendered if waiting time is reduced and reservoirs are addressed, patients' needs must be heard and addressed. Satisfaction by patients will never be reached if this important outcome of successful health care delivery is not addressed. Organisations need to learn from those that are successful in addressing this issue, for example, the National Health System of Scotland. They need to implement Best Practices to address their consumers' physical and mental anguish; otherwise they cannot purport to have delivered an effective and efficient health service.

### **4.4 Summary**

The findings in this chapter revealed that patients had common experiences about long waiting time at the community healthcare centre. These experiences were verbalised and put into the context of the Queuing Theory and the conceptual framework of the study. Patient satisfaction was the ultimate goal in the conceptual framework made up of the Batho Pele principles, the Patients' Bill of Rights, Patient Representation and Quality Care as the tools to reach this goal. It was found from the health care consumer's point of view that these tools were not in place, and the patients were also mostly unaware of



them at all. Patient dissatisfaction is thus the order of the day and leads to eruptions that have negative consequences for the staff especially in terms of how they are perceived by the patients. This was the only way they could express themselves when dissatisfied with waiting for services, in the absence of other complaints or communication structures like health forums/committees.

## **4.5 Conclusion**

In this chapter, the findings of the study and the solutions to the problems about the experiences of patients about waiting time at the CHC were discussed and presented in detail. In the next chapter recommendations based on the study and the limitation of the study will be presented including the final conclusion to this study.

## CHAPTER 5

# CONCLUSION, LIMITATIONS AND RECOMMENDATIONS

### 5.1 Introduction

Discussions in this chapter will focus on the interpretation of the interviews with consumers of health care about their experiences at Vanguard CHC about waiting time. The study goals and objectives will be discussed. The participants' suggested solutions to the problem of long waiting will be considered in the recommendations made as part of the study. The recommendations made by the participants need to be urgently addressed to improve overall patient satisfaction and thus contribute to the outcome measurement of quality care.

### 5.2 Discussion

The aim of the study was to explore the experiences of chronic patients about long waiting time at a Community Health Centre in the Western Cape. The objectives were to explore the patients' feelings as well as their possible solutions to the problem of waiting too long at the CHC.

#### ***5.2.1 Patients' feelings about long waiting time***

The conceptual framework presented patient satisfaction as the ultimate goal to strive towards and as an important measure of whether quality care was delivered. Results from this qualitative study shows that patients do not experience satisfaction with services, and that long waiting is too common. Patients feel that no measures seem to be in place at the CHC to effectively address the issue and so the problem persists and becomes worse. Queuing Theory was applied to describe the flow of patients through the day hospital, and the same conclusions were reached about the problematic flow at the CHC as in other African countries and amongst international health providers. Arrival to the CHC is not regulated, and emergency lines negatively influence the queuing discipline off first-come-first-out. Participants of this study mentioned the lack and inadequacy of servers from the reception through to the exit after pharmacy attendance. This results in reservoirs of patients accumulating in waiting areas and in an

unacceptable amount of waiting occurring. The reservoir areas identified by the participants are the same as those observed elsewhere on the African continent and internationally, namely the reception area, the doctors' waiting rooms and the pharmacy. From the participants' reactions one could assume that they were at their wit's end about the situation, and that they felt that government had to act urgently to address the situation by employing more staff.

Waiting resulted in physical and mental distress for patients because of their chronic conditions such as raised blood pressures, hypo- or hyperglycaemia, as well as exhaustion from having to walk long distances. Waiting also led to patients being unable to plan their day, thus creating feelings of disempowerment as there seems to be nothing that will improve the situation. This is a reflection on the inability of the staff to implement principles of Batho Pele which state that the patient must come first. It also is a reflection of the fact that the Patient's Rights Charter is not being adhered to as required. Furthermore it constitutes a general lack of interest in what the patients need and an inability to communicate the needs of the CHC and staffing situation to the patient so that the patient can understand issues about the cost structure that influences service delivery. Non-representation of the patient in his own care results in an experience of lack of quality care and accentuates the inability to satisfy the patient.

The literature review showed that the public health sector faces challenges to deliver high quality care service at the CHCs. The literature also offered examples of good practice from other countries' health care facilities ensuring that the patient experiences satisfaction with the health care delivered to them. These included measures such as improving delays at the pharmacy and increasing staff capacity at every point of the patient's journey through the flow. The National Health System of Scotland seems to be leading the way and one can learn from their experience. Government and management can strive towards providing satisfactory care as also defined by the patients within the available resources.

### ***5.2.2 Patient's suggested solutions to the problem of long waiting***

The solutions to long waiting time as proposed by patients are as follows:

#### 5.2.2.1 Recruitment of staff

There is an urgent need to have more staff at the CHC as identified by most participants. CHCs are public entities with a massive influx of patients since they offer a free service.

#### 5.2.2.2 Address the critical shortage of doctors

Apart from other staff shortages, participants also observed a lack of doctors on the premises. Although academic institutions like the University of Cape Town send their medical students there for community service, this is not primarily to help the patients but rather for the students to gain work experience. Thus, after they have had their necessary practical hours covered, they leave and the patients suffer accordingly, as no-one replaces them. Medical students that do community service in the CHC need to be better allocated by universities. There should be better communication between the medical faculty and the CHC about allocation as well as communication to patients about allocations.

Locum work by doctors could also be investigated as an option. The Western Cape as a popular place of employment in South Africa attracts doctors for locum work and employing them through an agency could possibly help address this problem.

#### 5.2.2.3 Address attitudes

Participants experienced rude, impolite and uncaring staff while waiting for the service. This disrespectful behaviour towards patients is common internationally according to literature in Chapter 2. Participants require staff and management to improve their attitude and behaviour to be able to comply with the Principles of Batho Pele and the Patients' Rights Charter. As circumstances that the staff work under are fraught with frustration due to all kinds of shortages, management really needs to brainstorm around this issue together with staff and have patient representation on such forums to ensure quality care and patient satisfaction.

#### 5.2.2.4 Improve supervision and leadership

Lack of leadership and supervision was identified and patients described the service as poorly organised, with doctors coming late and leaving early, nurses chatting and hugging each other, patients queuing in wrong queues.

Managers need to be evaluated and feedback must be given per inspection. There is a need to comply to quality care measurements for services and to improve, even if it is by small steps in the immediate future. COHSASA is a body that ensures quality and does inspections and ensure that recommendations are being carried out. It would do management and government good to investigate the possibility of such a body getting involved in order help them resolve the quality issues that impact negatively on patient satisfaction.

#### 5.2.2.5 Improve organisational planning

Participants voiced the need for a well-planned, well organised operational setting, whereby problems like long waiting time would be adequately addressed. They need to observe a smooth running of the service and some accountability if things do not work according to plan. Accountability can be obtained via regular meetings and feedback to staff as well as staff evaluations and feedback to determine if set goals are reached.

#### 5.2.2.6 Address areas where bottlenecks occur

Areas where overcrowding was noticeable was at the reception and dispensary areas. The bottleneck at the dispensary was due to patients coming from different service stations at the CHC to fetch medicines and resulting in pharmacy staff unable to cope with the load, thus adding to long waiting time. This is confirmed by Du Plessis (2008: 13) who cites this as one of the reasons why pharmacy staff is difficult to find, as the working conditions are extremely unpleasant due to the load as well as the impatience of patients they have to deal with.

More pharmacists, assistant pharmacists and administrative officers in reception area are needed as these service stations take more load than any other at the CHC. The NHS of Scotland suggests that the problem should be addressed starting at the point of exit (that is, the pharmacy) and once this is done the situation should then be addressed further back along the line where reservoirs are experienced. However, reception is should be an immediate priority at the Vanguard CHC because of missing patient folders and the lack of functioning computers. Staffing and equipment should be a priority to address in this area.

#### 5.2.2.7 Decentralise dispensing of chronic medication

Dispensing of chronic medication has added another load to the pharmacy with patients only coming for their repeats of chronic medication. The suggestion is that chronic medication should be dispensed at points nearest to where the patients stay to avoid overloading of the CHC pharmacy. There was also a suggestion to make use of volunteers to help with dispensing of these in the townships.

### **5.3 Limitations of the study**

The study has a few limitations that need to be mentioned:

#### **5.3.1 Focus on chronic patients only**

This study focused only on chronic patients who frequently visited the CHC for a period of more than a year and excluded the rest of the patients who could have also contributed more insight about the topic.

#### **5.3.2 Inability to generalise to other institutions**

The study was conducted in one CHC and was not compared with other centres in the Western Cape to give a broader picture of the status quo in the Western Cape or in the country at large.

#### **5.3.3 Staff component and their views not represented**

Staff at the CHC was not included in the study. Their opinions on reasons for long waiting time at the community health centre and the solutions to these reasons could also focus the attention on other issues that have not been considered in this study, for example staffing ratios, meetings held to address problems and plans implemented and the reasons for applied methods not working, sick leave profiles, inability to find agency staff or an inadequate budget to replace short-term absenteeism.

#### **5.3.4 Sample size**

A sample of twelve participants (n=12) was selected from a population of 2829 (N=2829). The sample size could have been larger but because of time constraints and recurrence of the same themes, the researcher kept it at twelve.

### **5.3.5 Lack of probing**

During the interviews with participants, the question about the personal effects of long waiting time at the CHC was only partly covered with some of the patients as most responses to this question were the same as for the question, “How does it make you feel when waiting for a long time?” It was difficult to probe some patients, as not all were very forthcoming with information, and English/Xhosa was not everyone’s home language, making it difficult to express themselves. Time was also an issue as not more than one hour per participant was available for an interview.

### **5.3.6 Equipment failure**

When the first audiotape recorder broke the researcher had to start the interviews all over again, using another approach. The lack of the input from those interviews contributes to the inability to generalise this study’s results to the whole population of the CHC.

## **5.4 Recommendations**

The following observation about the problem of long waiting time is made after combining the results of the study with findings from the literature and the conceptual framework:

Non-adherence to Batho Pele Principles and Bill of Rights, lack of patient representation and thus the inability to render quality of care will result in reduced patient satisfaction levels within the health care system or institution. Dissatisfaction with services is a symptom of non-adherence to these principles and the lack of quality care experienced by the consumers of health care.

The insights from the literature review and the interviews with the patients confirmed general dissatisfaction with care locally and internationally. The main theme of long waiting time has been identified as the cause of this dissatisfaction. The researcher recommends the following to address the dissatisfaction of customers of the CHC:

### **5.4.1 Recruitment and retention of healthcare professionals**

The previous chapters indicated that one of the main causes of long waiting time is the shortage of doctors and nurses. The need for recruitment of all categories of healthcare professionals is very important. The government needs to co-ordinate with the tertiary

institutions and engage on the intake of students in different disciplines so that estimations can be made in terms of the demands in the hospitals, clinics and CHCs.

An adequate and sufficient budget for the Department of Health to fill vacant post is essential. The freezing of posts results in staff shortages. Freezing posts is a common way of addressing budgetary shortages as the staff component of an institution is usually the most expensive aspect. The effect of freezing posts has to be weighed up against the negative results it has, for instance burnt-out staff and compromised quality of care and patient satisfaction levels that drop significantly. All too often management had a post frozen for so long and expected the staff to work at a deficit for so long, that it is conveniently forgotten that such a post existed, seeing that staff are now 'coping' anyway. A method should be in place to revise frozen posts regularly and force management to write motivations with the input from the rest of the staff stating why the post should filled.

Retaining staff is important; this can be done by removing barriers like poor working conditions and inadequate resources. Regular meetings with staff are necessary to understand their problems and reporting back to them about the status quo of vacant posts.

#### ***5.4.2 Attitudes of healthcare professionals towards patients***

The attitude of the health care personnel needs attention. The government has set standards by which all public sectors must conduct themselves to reduce perceptions patients have about healthcare professionals in terms of being rude, impatient, impolite and uncaring. The Principles of Batho Pele and the Patients' Bill of Rights discussed in previous chapters must be adhered to by healthcare professionals. These documents should be available to all staff members and new appointments and should be part of induction and in-service training programmes for healthcare staff. These documents should be displayed at the entrance of the CHC and along the path and corridors where they are visible to patients and staff to read. The staff should internalise these principles to be able to implement them.

#### ***5.4.3 Leadership and supervision***

CHC's need the type of leadership that will be able to identify, recognise and acknowledge that there is a problem with patients waiting long for the service and find



ways to solve the problems that exist. The problem of long waiting time has become a chronic problem. Good leadership will focus on identification of the problem, and determining possible solutions when the problem occurs. The patients should be consulted in solving these problems and a time frame in which to solve them must be set. Good leadership will be able to communicate and account to patients and staff in terms of the progress made.

The manager should be visible all the times to supervise all functions at the CHC and correct non-functional workflows. In essence the manager should be efficient, effective and competent in their role as a manager to avoid problems experienced by patients such as long waiting time.

Good leadership, good organisational planning and proper supervision are required to manage services properly. This requires the managers to be more vigilant and sensitive to patients' needs and complaints and act promptly.

#### ***5.4.4 Community Involvement***

The CHC needs to collaborate with the community to find common ground and produce solutions to problems that exist at the CHC. Building relationships with the community enables the community to trust the management and this will result in mutual respect for each other. Formation of health care committees to ensure patient representation will assist in engagement between members of the community and management.

#### ***5.4.5 Monitoring and evaluation of the services***

Evaluation is necessary to determine if the outcome measurement of quality care has been reached, whether the outcome is positive or negative. Ongoing monitoring and evaluation of the performance of the CHC is important so that staff know where they stand in terms of service delivery. This can be done by conducting waiting time surveys, audits and inspections on service delivery and the results acted upon. The purpose of the monitoring and evaluation of services is to identify shortcomings and inefficiencies and to then address the identified shortcomings. After the findings of such monitoring, Standard Operational Procedures need to be developed and applied to prevent the shortcomings recurring. Eventually this will lead towards excellent service.

#### **5.4.6 Complaint System Procedure**

To complain about service is the patients' rights according to Batho Pele Principles. Every single patient should be made aware of the complaints procedure. The patient must be guaranteed that the complaint will be attended to and feedback will be within a certain time frame.

Compliments, if any, should also be included to give the staff and management some form of satisfaction and direction. Suggestion boxes should be available and be visible to patients and checked regularly by staff and management.

#### **5.4.7 Fast tracking of patients**

Patients often stand in the wrong queues and this causes delays. Patients should be directed or sign posts made available and visible so that patients can follow directions. Help desk officers should be able to assist in this matter. Patients who are coming for dressings and injections should not be waiting in a general queue waiting for the doctor.

#### **5.4.8 Patient-centred approach to achieve patient satisfaction**

The patient is the best source of information to determine whether consumers are treated with dignity and respect (Chaka, 2005: 3). They should thus continuously be involved in evaluation of the process of care delivery. A patient-centred approach sees quality care as one in which the patient is actively involved in health care delivery and evaluation

The technical dimension of quality care delivered to a patient includes all the technical/clinical procedures that are performed so that the patient's condition improves. The non- technical dimension includes empathy, comfort, addressing the patient's social needs and overall sensitivity and courtesy towards the patient. A patient-centred approach puts the needs of the patient first and this aspect has been included in the 2020 Health Plan for the Western Cape.

With a patient-centred approach patient satisfaction is the determining factor of quality care services rendered. In this study, the Patients' Bill of Rights, the Batho Pele Principles, Patient Representation and Quality Care are the vehicles by which to ensure that patients' needs are addressed and the goal of patient satisfaction is reached. Quality care and an excellent service causes a patient to come back without doubts

about service delivery and this will also reduce patients' non-compliance and defaulting on treatment.

## **5.5 Conclusion**

The findings of this study were discussed in relation to the study objectives stated in the previous chapters. The aim of the study was to explore the experiences of chronic patients' about long waiting time at a CHC in the Western Cape.

The study found that patients wait long at the CHC for service and this resulted in patients being dissatisfied about the service delivery to them. These findings correlated with the literature search about long waiting time, which shows that long waiting time are experienced worldwide, in all health provider settings. In all the studies nationally and internationally patients were at the receiving end of this problem of long waiting times and their voices needed to be heard as the users of the service, to properly address the problem. Patients identified the reasons for long waiting time as being due to the shortage of staff, improper planning, overcrowding and poor leadership and supervision.

The findings of the study support the conceptual framework which included the views contained in the Patients' Bill of Right, the Principles of Batho Pele, the idea of Quality Care and Patient Representation – all factors that must be considered in order to obtain Patient Satisfaction. These concepts are linked and are interrelated. The concepts, if implemented properly and in unison, will improve service delivery and will result in excellent service and patient satisfaction. Patient satisfaction as a measurement of the effectiveness of health care delivery is absolutely vital. As such, patient-centred quality of care is at the core of the vision for 2020 and that is a step in the right direction.

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## **APPENDICES**

### **APPENDIX A: DATA COLLECTION TOOL: INTERVIEW GUIDE**

- What are the causes of long waiting time at a community health care centre?
- What are the areas of concern where you wait long at a community health centre?
- Is there any communication by staff when you wait long?
- What are the emotions that arose when you wait long at a community health centre?
- What are the effects of long waiting time?
- What are the emotions that arose when you wait long at a community health centre?
- What are the proposed solutions solutions to long waiting time?

## APPENDIX B: ETHICAL COMMITTEE APPROVAL LETTER



UNIVERSITEIT • STELLENBOSCH • UNIVERSITY  
jou kennisvennoot • your knowledge partner

25 May 2011

**MAILED**

Miss V Tana  
Department of Nursing  
2nd Floor  
Teaching Block

Dear Miss Tana

The experiences of patients about waiting times at a Community Health Centre in the Western Cape.

**ETHICS REFERENCE NO: N11/04/111**

**RE : APPROVAL**

A panel of the Health Research Ethics Committee reviewed this project on 26 April 2011; the above project was approved on condition that further information is submitted.

This information was supplied and the project was finally approved on 25 May 2011 for a period of one year from this date. This project is therefore now registered and you can proceed with the work.

Please quote the above-mentioned project number in ALL future correspondence.

Please note that a progress report (obtainable on the website of our Division: [www.sun.ac.za/rds](http://www.sun.ac.za/rds)) should be submitted to the Committee before the year has expired. The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly and subjected to an external audit. Translations of the consent document in the languages applicable to the study participants should be submitted.

Federal Wide Assurance Number: 00001372

Institutional Review Board (IRB) Number: IRB0005239

The Health Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

Please note that for research at a primary or secondary healthcare facility permission must still be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms Claudette Abrahams at Western Cape Department of Health ([healthres@pgwc.gov.za](mailto:healthres@pgwc.gov.za) Tel: +27 21 483 9907) and Dr Hélène Visser at City Health ([Helene.Visser@capetown.gov.za](mailto:Helene.Visser@capetown.gov.za) Tel: +27 21 400 3981). Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

Approval Date: 25 May 2011

Expiry Date: 25 May 2012

25 May 2011 14:59

Page 1 of 2



Fakulteit Gesondheidswetenskappe • Faculty of Health Sciences



Verbind tot Optimale Gesondheid • Committed to Optimal Health  
Afdeling Navorsingsontwikkeling en -steun • Division of Research Development and Support  
Posbus/PO Box 19063 • Tygerberg 7505 • Suid-Afrika/South Africa  
Tel.: +27 21 938 9075 • Faks/Fax: +27 21 931 3352



## APPENDIX C: APPROVAL TO COLLECT DATA AT VANGUARD CHC

28/09/2012 09:24 0214839895

FINANCE

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**STRATEGY & HEALTH SUPPORT**  
healthres@pgwc.gov.za  
tel: +27 21 483 9907; fax: +27 21 483 9895  
1st Floor, Norton Rose House, 8 Riebeeck Street, Cape Town, 8001  
[www.capegateway.gov.za](http://www.capegateway.gov.za)

REFERENCE: RP 122/2012  
ENQUIRIES: Dr Sikhumbuzo Mabunda

Corner of candlewood & Citrus Road  
Bonteheuwel  
Cape Town

For attention: Vuyiswa Tanga

**Re: Experiences of patients about long waiting time at a Community Health Centre.**

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research. Please contact the following people to assist you with any further enquiries.


**Vanguard CHC                      Mr L Mbanga                      (021) 695 5760**

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final report within six months of completion of research. This can be submitted to the provincial Research Co-ordinator ([healthres@pgwc.gov.za](mailto:healthres@pgwc.gov.za)).
3. The reference number above should be quoted in all future correspondence.

We look forward to hearing from you.

Yours sincerely

  
DR NT Naledi  
DIRECTOR: HEALTH IMPACT ASSESSMENT  
DATE: 22/9/2012

CC

DR K GRAMMER

DIRECTOR: SOUTHERN/WESTERN

## APPENDIX D: CONSENT FROM DEPARTMENT OF HEALTH TO CONDUCT RESEARCH



### DEPARTMENT of HEALTH

Provincial Government of the Western Cape

#### Vanguard Community Health Centre

[Lmbanga@pgwc.gov.za](mailto:Lmbanga@pgwc.gov.za)

[Lalfrede@pgwc.gov.za](mailto:Lalfrede@pgwc.gov.za)

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Cnr. Candlewood & Citrus Str. Bonteheuwel, 7764

[www.capegateway.gov.za](http://www.capegateway.gov.za)

**REFERENCE:** Research

**ENQUIRIES:** Mr. L.L. Mbanga

---

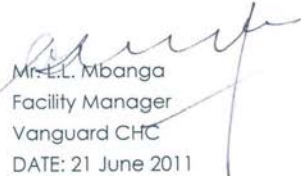
**For attention:** Sr. V. Tana

**Student No:** 15230317

**Regarding:** Waiting time research

Thank you for submitting your proposal to undertake the above-mentioned research.  
I am pleased to inform you, that approval have been granted for your research.

Thanking you

  
Mr. L.L. Mbanga  
Facility Manager  
Vanguard CHC  
DATE: 21 June 2011

## APPENDIX D: VALIDATION REPORT FROM AN INDEPENDENT RESEARCHER

UNIVERSITY OF CAPE TOWN



### Division of Family Medicine

School of Public Health and Family Medicine

Faculty of Health Sciences

Anzio Road

Observatory 7925

SOUTH AFRICA

Telephone: (27 21) 406 6510

Fax: (27 21) 406 6667

8 December 2011

To whom it may concern:

Re: Validation report

Student: Vuyiswa Veronica Tana

Stellenbosch University student no: 15230317

Course: M. Cur.

Dear Course convener

This is to acknowledge that the above mentioned student requested me to validate whether the Xhosa paper-based interviews that she had carried out were properly translated into English. My intervention therefore became assisting the student to edit the translated scripts.

Based on my knowledge of Qualitative research, I am satisfied that the edited transcribed scripts have not lost their meaning.

Sincerely,

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## APPENDIX E: PARTICIPANT CONSENT FORM

### PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

#### TITLE OF THE RESEARCH PROJECT:

**Experiences of patients about long waiting times at a Community Health Centre in the Western Cape.**

**REFERENCE NUMBER: 15230317**

**PRINCIPAL INVESTIGATOR: Vuyiswa Veronica Tana**

**ADDRESS: 28 Downing Street Montana 7490**

**CONTACT NUMBER: 0836042875**

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the study staff or doctor any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the **Health Research Ethics Committee (HREC) at Stellenbosch University** and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

#### **What is this research study all about?**

The research is about exploring the participants' experience and feelings about long waiting time at a Community Health Centre.

*The study will be conducted in one of the community health centres in the Western Cape. The total number of participants will be 10.*

*The aim of the project is to explore the experiences of patients' waiting times in a Community Health centre in the Western Cape and possible solutions to this problem.*

*The researcher should ask participant if he/she is willing to participate in the study as he /she is waiting in the line. The patients that will be asked to participate in the study will be those that visit the community health centre more frequently, chronic patient with diseases of lifestyle and those who participate in health education.*

*The researcher will explain to the participants what the research is all about. The participant will be asked to fill in consent form. The researcher will explain to participants that the research is confidential and participants will remain anonymous.*

**Why have you been invited to participate?**

- You are invited to participate in the study because you are affected by waiting time at the community health centre and you visit the community health centre more frequently. You are also invited to give your own experiences and possible solutions to this problem.*

**What will your responsibilities be?**

- Your responsibility will be to give your opinion about your experiences and possible solutions to this problem.*

**Will you benefit from taking part in this research?**

- Your input will enable the health care providers and policy makers to make changes and improve waiting by patients at community health care centres. There are no personal benefits, but because of your involvement in the study patients in future will likely benefit.*

**Are there in risks involved in your taking part in this research?**

- There are no risks involved in the study. Your input will be treated anonymously and confidential.*

**If you do not agree to take part, what alternatives do you have?**

*The research study is voluntary. We respect the opinion of a participant who does not agree to take part in the research study. The participant can withdraw from the study at any time if he/she feels uncomfortable.*

**Who will have access to your medical records?**

- The principal investigator will have access to your records through your permission. The information collected will be treated as confidential. Identity of the participant will remain anonymous. All information provided by you will be used only for the purpose of the study and your name will not be used in any report or data in the study.*

**What will happen in the unlikely event of some form injury occurring as a direct result of your taking part in this research study?**

- The research study will not involve any danger that can cause injury to oneself or others.*

**Will you be paid to take part in this study and are there any costs involved?**

You will not be paid by taking part in the study and there is no cost involved if you do take part.

**Is there anything else that you should know or do?**

- You will receive a copy of this form and consent form for your own records.
- You can contact the **Health Research Ethics Committee** at 021-938 9207 if you have any concerns or complaints that have not been adequately addressed by your study doctor.
- You will receive a copy of this information and consent form for your own records.

**Declaration by participant**

By signing below, I ..... agree to take part in a research study entitled (*insert title of study*).

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the study doctor or researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) ..... on (*date*) ..... 2009.

.....  
**Signature of participant**

.....  
**Signature of witness**

**Declaration by investigator**

I *Vuyiswa Veronica Tana*..... declare that:

- I explained the information in this document to .....

- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use a interpreter. (*If an interpreter is used then the interpreter must sign the declaration below.*)

Signed at (*place*) ..... on (*date*) ..... 2009.

.....  
**Signature of investigator**

.....  
**Signature of witness**

### **Declaration by interpreter**

I (*name*) ..... declare that:

- I assisted the investigator (*name*) ..... to explain the information in this document to (*name of participant*) ..... using the language medium of Afrikaans/Xhosa.
- We encouraged him/her to ask questions and took adequate time to answer them.
- I conveyed a factually correct version of what was related to me.
- I am satisfied that the participant fully understands the content of this informed consent document and has had all his/her question satisfactorily answered.

Signed at (*place*) ..... on (*date*) .....

.....  
**Signature of interpreter**

.....  
**Signature of witness**